PERSONAL AND FAMILIAL CHARACTERISTICS IN THE ADOPTION OF FAMILY WELFARE PROGRAMMES: AN ANALYSIS OF LODHA BLOCK, ALIGARH

THESIS ABSTRACT

SUBMITTED FOR THE AWARD OF THE DEGREE OF

Doctor of Philosophy

IN

SOCIAL WORK

BY

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UNDER THE SUPERVISION OF

Prof. Noor Mohammad

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ABSTRACT

It is rightly noted that there is no shortcut to population stabilisation. There is no substitute to sustained good work. We must create a situation where people would ask for health and family planning services. This implies an urgent need to understand the dynamics in the adoption of family welfare programmes. Further, the family planning/welfare programmes has been persistently being criticised for their focus on couples which smacks of western individual centric approach. It is in this backdrop, the present study is a modest attempt with a central objective- *to understand dynamics of personal and familial characteristics in the adoption of family welfare programmes*. Thus study focuses on the following objectives-

1. To analyse and assess the influence of socio-economic correlates, and the personal and familial characteristics in the adoption of family welfare programmes.

2. To analyse the nature and impact of rural women reproductive trajectory in the adoption of family welfare programmes.

3. To explore the intra-house dynamics of communication and power relations in the adoption of family welfare programmes.

4. To understand how personal and familial characteristics operate to influence the process of contraceptive adoption.

In the light of objectives, following hypotheses are posited for verification in this study-

1. Higher is the caste, education, income and outside employment, higher is the adoption of family welfare programmes.

2. Poorer the reproductive trajectory of woman, poorer the adoption of family welfare programmes.

3.1 Higher the scope of discussion on family issues (wider the communication domain), higher the adoption of family welfare programmes.

3.2 Higher the mutual decision making in family, higher the adoption of family welfare programmes

4.1 More positive the personal and familial response to contraceptive methods, more the adoption of contraceptives.

4.2 More participatory the decision making process, more the adoption of contraception.

The present research is a micro exploratory study of the adoption of family welfare programmes. Given the collective and unique nature of Indian rural family, as a social institution, the family is taken as a unit of study. Further, the collective value system of Indian society, ethos and community solidarity are preserved and mutates through the institution of family, of which fertility behaviour and adoption of family welfare programmes are no exceptions. Further, the family as unit of study takes the present research more close to

Indian model of social work instead of western social work unit 'individual' and family welfare programmes much-criticised unit 'couple'. The present research focuses on analysis of Lodha block, which lies in the district of Aligarh, Uttar Pradesh. The study is restricted to a sample of 150 households consisting of 75 sterilisation adopters (adopters) and 75 non-sterilisation adopters (non-adopters). In the collection of primary data, both survey method and qualitative techniques like FGDs, case studies, key informants and also 'informal discussions' are used. The approach was to supplement the quantitative data with dense qualitative data. The use of secondary data is restricted to facts and figures and is collected from Census data, block data and PHC. The data thus collected are analysed and inferences are drawn accordingly with the help of percentages, mean averages and two-tailed t-test and to crystallise subtle dimensions the FGDs and case studies are used.

The thesis is divided into seven chapters. The first chapter is devoted to building of research argument. It outlines the major population debates and researches in fertility and family planning and the rationale and relevance of undertaking this research. The second chapter is on research methodology, which sets the path to pursue present research. The chapter three is on personal and familial determinants of contraceptive adoption in rural milieu. The fourth chapter discusses the rural reproductive trajectory; the fifth chapter explores the dynamics of communication and power relations; and the sixth chapter analyses the process of contraceptive adoption. Basically, these chapters from three to six deal with the each major objective of the study. Each of these chapters first dwells heavily on related studies and thereafter the

results from the data analysis of present research are discussed and inferences drawn accordingly. The thesis end with chapter seven on conclusion and ways forward.

The results of the present study are summarized here with reference to the objectives of the study and the hypotheses set forth for testing:

The study attempted to find out how the personal and familial characteristics become operative under the influence of socio-economic variables and thereafter analyses the major personal and familial characteristics of adopters and non-adopters. The research began with an analysis of data on major and much acknowledged and commented upon socio-economic variables determining fertility and family planning adoption. The data is collected with regard to religion, caste, family type, land holdings and political participation. With regard to socio-economic correlates it may be inferred that in sampled population, religion as a category (across Hindus and Muslims) is not significant while caste is significant at least in sterilisation adoption. SCs are better sterilisation adopters however in case of temporary contraception SCs and general category are at same platform while OBCs performed better. The family typology also does not present a clear picture but in case of sterilisation nuclear families are more conducive. Further, in terms of land holding and political participation, the sample population have poor profile however those belonging to these categories are either adopters or have positive inclination towards family welfare programmes. The qualitative data more thoroughly reflect that these socio-economic correlates govern and operationalise subjective realms of adopters and non-adopters. For example, religion as an

It may be inferred that the poor reproductive trajectory of rural women force them to take recourse in adoption of sterilisation which to them is more safer than unsafe abortions or being further puzzled of pregnancies, child care and household managements that also with limited incomes. This area require much needed attention of public health agenda and can be fruitful for both saving the mothers and promoting the family welfare programmes.

In order to understand the significance of intra-house dynamics of communication and power relations, the present research dwelled across two hypotheses, one on communications domains and another on process of decision-making in the family. The adopters have communication domains than non-adopters and hence the hypothesis that higher the scope of discussion on family issues (wider the communication domains), higher is the adoption of family welfare programmes is tested true. Similarly, the decision making of these issues have variations across the issues and also among adopters and non-adopters. The data show that unlike general issue like domestic problems, economic problems and even child upbringing, the intimate issues like personal health and hygienic, and the issues of small family and family limitation differs in decision making matters and these dynamics have to be considered in any mobilization for small family norm or adoption of family planning. It is also clear from the data that among adopters there is more mutual decision-making and this again supports the proposed hypothesis that higher the mutual decision making in family, higher the adoption of family welfare programmes.

It thus came out from data analysis that in case of temporary contraception responses are more of simple consent and encouragement than of indifference and even there is no response of rejection. Among non-adopters, the responses are more relatively more positive than adopters. However, the process of decision-making is more participatory among adopters than non adopters and probably the same speak of high percentages of adopters in ever-temporary contraception than non-adopters. Similarly, in case of sterilisation also there is either more mutual decision-making (all adopters, their spouses and significant others) or extreme unilateral decision by women. It may be noted that in case of temporary contraception there was not even a single case of mutual decision-making, this again justifies that in case of sterilisation whole family becomes active thus decision making becomes complex. Thus the hypotheses: i. more positive the personal and familial response to contraceptive methods, more the adoption of contraceptives; and ii. more participatory the decision making process, more is the adoption of contraception are tested true.

In view of intensive data analysis, insight gained from key informants, FGDs and case studies, it is amply clear that the contraception adoption is a dynamics process involving 'family' as a whole rather than individuals. Further, the mutual discussions and mutual decision-making process becomes more important as one moves from adoption of temporary contraceptives to permanent methods like sterilisation. It can thus safely be argued that- higher is the synchronisation between personal and familial characteristics, higher is the adoption of family welfare programmes.

It came out from the results of present research that if proper threshold energy is provided to speed up process of contraceptive adoption at personal and familial level (i.e. at family level), than the family planning catch segment will not be the exhausted generation but the potentials groups to substantially strike at TRF. It has also become very evident that unlike sterilisation there are not much inhibitions regarding temporary contraception, rather there is high unmet need. However, the hassles and infectiveness of temporary contraceptives is a cause of concern among the sampled population. From the qualitative data it became crystal clear that the only missing link is the lack of proper counselling and clarification regarding temporary contraceptives which results in incorrect and inconsistent use of temporary contraceptive and hence the resultant effectiveness. It also came out that due to delay in process of decision-making for sterilisation and ineffectiveness of temporary contraception, the women attempt fatal traditional concoctions and unsafe abortions. Thus, there is need of concrete steps for developing such groups within community who can act as catalysts to provide the much needed threshold energy. It is here that the study proposes the proactive role of Panchayati Raj Institutions (PRIs) and the professional social workers to provide true momentum to Cairo goal of informed choices in contraceptive adoption under the umbrella concept of Reproductive Health (RH).

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CERTIFICATE

This is to certify that **Mr. Mohd Shahid** has worked under my supervision for his Ph.D. thesis entitled "**Personal and Familial Characteristics in the Adoption of Family Welfare Programmes: An Analysis of Lodha Block, Aligarh**". He has completed all the necessary requirements prescribed in the Academic Ordinances and his research work is original and suitable for the submission for the award of Ph.D. degree in Social Work.

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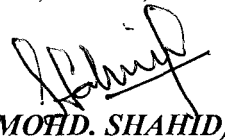

(MOHD. SHAHID)

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LIST OF ABBREVIATIONS

ADP	Area Development Programme
ANC	Antenatal Care
ANM	Auxiliary Nurse Mid-wife. ANM is the infantry of Indian health care delivery system which links people with health system.
ASHA	Accredited Social Health Activist. ASHA is a grassroots level volunteer of ambitious National Rural Health Mission (NRHM) to motivate, mobilise and link masses with health care delivery system. AHSA is given incentives for her efforts.
AWW	Ānganwādī Worker. AWW is a grassroots level worker of Integrated Child Development Services (ICDS) scheme of Indian government. Each Ānganwādī Centre (AW) covers a population of 1000 and provides pre school education to children (3-5 years), supplementary nutrition to pregnant and nursing mothers along with mal-nourished children. Ānganwādī centres also involves adolescents so as to train them to become good mothers.
BIMARU	An acronym used by Ashish Bose for the four demographically poor performing states that is Bihar, Madhya Pradesh, Rajasthan and Uttar Pradesh
CBD	Community based Distributor
CBR	Crude Birth Rate
CDR	Crude Death Rate
CHC	Community Health Centre. It is manned by four specialists i.e. Surgeon, Physician, Gynaecologist and Paediatrician and supported by 21 paramedical and other staff. A CHC has 30 indoor beds with one OT, X-ray facility, a labour room and laboratory. It serves as a referral centre for 4 PHCs. It covers a population of 120000 in plain areas and 80000 in hilly/tribal areas
CMC	Community Mobilisation Coordinator. CMC is a field level volunteer of UNICEF, social mobilisation network (SM Net) on polio eradication
CNAA	Community Need Assessment Approach
CPR	Contraceptive Prevalence Rate/ Couple Protection Rate
CSM	Contraceptive Social Marketing

CSSM	Child Survival and Safe Motherhood
Cu-T	Copper- T, a variety of IUD/IUCD
DANIDA	Danish International Development Assistance
DEMARU	An acronym used by Ashish Bose for the states with sharp decline in child sex ratio that is Punjab, Haryana, Himachal Pradesh and Gujarat
DFID	Department for International Development (UK)
FGD	Focus Group Discussion
FPAI	Family Planning Association of India
GOI	Government of India
ICPD	International Conference on Population and Development
IFA	Iron, Folic Acid and Vitamin A
IMR	Infant Mortality Rate
IPPF	International Planned Parenthood Foundation
IUD/IUCD	Intra-Uterine Contraceptive Device
KAP	Knowledge, Attitude and Practice of family planning
MCH	Maternal and Child Health
MOHFW	Ministry of Health and Family Welfare
MPS	Mysore Population Study
MTP	Medical Termination of Pregnancy
NCP	National Commission on Population
NFHS	National Family Health Survey. In India, two major NFHS surveys are conducted at all India level in base years 1992-93 and 1998-99 and published for all India figures in 1995 and 2000 respectively (specific states have different years of publication) by International Institute for Population Studies (IIPS), Mumbai.
NGO	Non-Governmental Organisation
NIFP/NIFW	National Institute of Family Planning/Welfare
NIHA	National Institute of Health Administration
NPC	National Planning Committee
NPP	National Population Policy
NRHM	National Rural Health Mission
NRR	Net Reproduction Rate
NSV	Non Scalpel Vasectomy
OBCs	Other Backward Classes

OCPs	Oral Contraceptive Pills
OICL	Oriental Insurance Company Ltd.
PC	Planning Commission
PFI	Population Foundation of India
PHC	Primary Health Centre. It is the first contact point between village community and medical officer. Manned by a Medical Officer and 14 other staff, it acts as a referral unit for 6 sub-centres and has 4-6 beds for patients. It performs curative, preventive, promotive and family welfare services. It covers a population of 30000 in plain areas and 20000 in hilly/tribal areas
PRC	Population Research Centre
PRIs	Panchayati Raj Institutions
RCH	Reproductive and Child Health
RGI	Registrar General of India
RH	Reproductive Health
RTI	Reproductive Track Infection
SC	Sub-Centre. It is the first peripheral contact between community and health care delivery system. A Sub Centre is manned by one female health worker (ANM) and one male health worker (MPW). One Lady Health Visitor (LHV) for six sub-centres is provided for supervision at the PHC level. A sub-centre covers a population of 5000 in plain areas and 3000 in hilly/tribal areas
SCs	Scheduled Cates. SCs are nowhere defined in the Indian official documents, and technically refer to all those castes specified in the notification issued and modified by virtue of Article 341 of Indian Constitution.
SIDA	Swedish International Development Agency
SIFPSA	State Innovations in Family Planning Services Project Agency
SMP	Social Marketing Programme
SRS	Sample Registration System
STI	Sexually Transmitted Infections
STs	Scheduled Tribes. STs, like SCs, are nowhere defined in the Indian official documents and technically refer to all those castes specified in the notification issued and also modified by virtue of Article 342 of Indian Constitution.
TBA	Traditional Birth Attendant

TFR	Total Fertility Rate and is defined as the average number of children that would be born to a woman if she experiences the current fertility pattern throughout her reproductive span (15-49 years)
TT	Tetanus Toxide
UK	United Kingdom
UN	United Nations
UNFPA	United Nations Fund for Population Activities/ United Nations Population Fund
UNICEF	United Nations Children's Fund
UP	Uttar Pradesh
US/USA	United States of America
USAID	United States Agency for International Development

GLOSSARY

The technical terms, local and colloquial words with their approximate meaning are listed below. The local terms are italicised and to ensure their correct pronunciation, the diacritical marks are used. Long vowels are indicated by a dash (-) over the letters to indicate the phonetic difference.

agwāni	reception of bridegrooms marriage party by bride's family
ajwāin	a kind of aromatic seed (thymol)
andā	egg
aprēsan	colloquial word for female sterilisation
autānā	to boil
autī	boiled liquid/ concoction
avatār	incarnation (new version)
bachchā girnā	natural/ spontaneous abortion
bachchā girvānā	induced abortion
bahu	daughter-in-law
bātchīt	literally meaning talk but used as a code for mating
bētā	son
bētī	daughter
bīj	seed
bīmār	sick
brahmacharya	self-control
chāy ki patti	tea leaves
dāi	traditional birth attendant
dāmad	son-in-law
gājar	carrot
garam	hot
garbhwatī	pregnant
garmī	heat

gaunā	consummation of marriage i.e. ceremony in which bride finally left for grooms house. This practice used take place when child marriages are solemnised (*vivah*) but bride continues to stay at her natal home till maturity and thereafter gaunā is done. (Technically age of marriage is counted as the age of consummation)
goli	used for oral contraceptive pills
grām	village
gud	jaggery
haldi	turmeric
kachchā	raw
kādā	literally boiled liquid like soup. The term is used for a variety of boiled liquid concoctions which are taken hot to abort the child
kubuddhī	bad advice
laung	clove
māhwāri	menstruation
māmā	maternal uncle
mantrā	magical formulae
muklāwo	consummation of marriage, the term is common in Rajasthan and its counterpart in Uttar Pradesh is *gaunā*
nāl	umbilical cord
nasbandi	sterilisation
naukri	service
nirodh	a type of condom
panchāyat secretary	with the empowerment of PRIs and devolution of powers to *pradhans*, elected head of panchāyat, and to facilitate them in effective working the panchāyat secretary is appointed. One secretary covers over 2-3 gram panchāyats
panchāyatī rāj	Local Self Governance
pāni bēl	water born plant having cold properties and is used for contraception
pradhān	elected representative of rural local bodies called as *grām* panchāyats.
safāi	literally cleanliness but used for abortion
sās	mother-in-law
sasur	father-in-law
shādī	consummation of marriage, a Urdu term for marriage among Muslims

śrddha	performance of rituals on the pyre
tākat ki goli	used for IFA (Iron, Folic Acid and Vitamin A) tablets
tari	coldness, but used for any concoction which is cold in nature and is used for contraception
tehsīle	sub- district
thandā	cold
tīka	injection, for example tetanus injection
vivāh	wedding, also see *gaunā*

CHAPTER-1

CONCEPTUAL FRAMEWORK

CHAPTER-1

Conceptual Framework

Much is being said and written on population, fertility behaviour, birth control, family planning or family welfare programmes or the more recent *avatār* reproductive health[1], that any attempt to enter in this arena, the research worth and uniqueness immaterial, seems to be on beaten tracks and needs 'overt justification' even before the start. Almost, two and half decades earlier Bose himself felt strongly to justify the necessity of his voluminous *From Population to People* because, to borrow his own words, 'an information explosion has overtaken the population explosion.'[2] In fact, the decade's 1960s-70s[3] and even 1980s did witness a spate of books and edited volumes each *par excellence* and each recalled that the bulk of literature on subject was written even before the Indian Independence[4]. A great many bibliographies were prepared listing number and nature of population studies undertaken specially after 1951-52 i.e. official launch of family planning programme. The

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[1] The ICPD (International Conference on Population and Development) definition of Reproductive Health (RH) is: A state of complete physical, mental and social well being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and its functions and processes. See UN, "International Conference on Population and Development, Cairo, Egypt, Sep. 5-13, 1994," (United Nations (A/CONF. 171/13), 1994).

[2] Ashish Bose, *From Population to People*, 2 vols., vol. I (Delhi: B.R. Publishers Corp, 1988)., Preface, p. xiii.

[3] The period between 1960s-70s is considered as the 'golden period in demography'. See Tulsi Patel, *Fertility Behaviour- Population and Society in a Rajasthan Village*, (First published in 1994) 2nd ed. (New Delhi: Oxford University Press, 2006)., p. xxii.

[4] The term here is simply used to highlight the urgency of problem and to distinguish the studies that were undertaken before and after Indian Independence from British yolk in 1947.

question becomes further important as the closing eyes of the previous millennium witnessed International Conference on Population and Development (in 1994 at Cairo, Egypt) which marked the paradigm shift with passionate addition and deletion of 'terms', 'concepts' and 'strategies' to usher with a new 'Plan of Action'. The new millennium witnessed influx of studies dwelling on ICPD plan of action and rhetoric for individual and reproductive rights; client-centred, demand driven and target free approach.[5] Furthermore, World Conference on Women (in 1995 at Beijing, China) also stressed the 'explicit recognition and reaffirmation of the rights of all women to control all aspects of their health, particularly fertility.[6] Thus, further flattening the size of question mark on the rational of study, that also one which dwells on family welfare programmes and the determinants of contraceptive adoption? There is yet another important and interesting question quite authoritatively being posed that there is nothing like a population problem, and this question accordingly questions the very relevance of a study on family planning. They boldly quote that 'development is the best contraceptive'[7] (without knowing

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[5] Today, there is so much concern and apathy to data, targets and number-settings (like reduction in birth rate, CPR and TFR achievements) that Bose titled his most recent work as *Beyond Demography* and argues that many of technical demographers, both in India and abroad, get so engulfed by data that they often fail to dwell on the more important non demographic issues, particularly, socio-cultural practices. See Ashish Bose, *Beyond Demography- Dialogue with People* (Delhi: B.R. Publishing Corp, 2006)., Preface, p. ix. Elsewhere he has described family planning target chasing (for 'case') as a disease which he calls ***targetitis***. See Ashish Bose, "The Family Welfare Programme in India: Changing Paradigm," in *The Family Welfare Programme in India*, ed. Hari Mohan Mathur (New Delhi: Vikas Pub. House in association with the HCM Rajasthan State Institute of Public Administration, 1995)., p. 8.

[6] Austreberta Nazar Beutelspacher, Emma Zapata Martela, and Veronica Vazquiz Garcia, "Does Contraception Benefit Women? Structure, Agency and Well Being in Rural Mexico," in *Capabilities, Freedom and Equality- Amartya Sen's Work from a Gender Perspective*, ed. Bina Agarwal, Jane Humphries, and Ingrid Robeyns (New Delhi: Oxford University Press, 2006)., p. 258.

[7] This much quoted slogan was given by Dr. Karan Singh, then Minister of Health and Family Planning, Government of India at World Population Conference (Bucharest, 1974). Interestingly, same Minister back at home in 1976 formulated and executed a population

how much steadfast to it was the very person who gave this *mantra*). At this juncture, suffice it is to take recourse in Asok Mitra's apt assertion, 'wholly unnecessary and harmful rigid postures have been taken. Champions of economic growth have ignored the harmful effect of runaway population growth. Champions of population control have underestimated the utter necessity of economic growth. Few have stressed that *economic growth and population control are the two sides of the same coin.....Overstatement in any direction can create undue optimism with its inevitable backlash of disappointment and despair* and nothing is so hurtful to a nation's progress as pessimism and loss of self confidence [italics mine].'[8] Talwar[9] similarly noted that the role of population becomes very crucial in the economic growth of countries like India where resources are already over stretched to meet the current needs of the population.

Interesting are many more questions, most of which are adequately answered by a plethora of past studies, but few questions seem to be quite perennial and hence, pave way for the present research. The subsequent paragraphs will unearth, with parsimony to abundant literature, the necessity of this study.

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policy which contained 'a permissive clause for the states to introduce compulsory sterilisation, if they want to do so.' See Bose, *From Population to People.*, p. xxii.

[8] Asok Mitra, "The Small Family Norm and Literacy," in *Studies in Demography- Essays Presented to Professor S. Chandrasekhar on His Fifty-First Birthday*, ed. Ashish Bose, P.B. Desai, and S. P. Jain (London: George Allen and Unwin, 1970)., pp. 290-291.

[9] Prem P. Talwar, "Determinants and Consequences of Rapid Population Growth," in *The Family Welfare Programme in India*, ed. Hari Mohan Mathur (New Delhi: Vikas Pub. House in association with the HCM Rajasthan State Institute of Public Administration, 1995)., p. 53.

1.1 Understanding Global Population Debates- from pre-Malthusian prescriptions to Malthusian prognosis and neo-Malthusian ascendancy

The historical studies abound discussion on mortality.[10] However, during the latter part of the 20th century, one of the three main processes of population, fertility which has more than the other two processes, that is, mortality and migration, attracted attention for research and policy purposes.[11] This increasing fervent of population studies (or more specifically studies on population growth) rests on Malthusian pessimism of historic past and prospective neo-Malthusian takeover. However, there was also the period when population growth was a welcome omen turned upside-down as Malthusian *mantras* became acceptable. This sub-chapter, although restricted only to fertility as one of population processes, attempts a panoramic view of population debates from pre Malthusian prescriptions to Malthusian prognosis and thereafter series of post Malthusian melodies making Malthus immortal. The forthcoming paragraphs in this sub-chapter rely heavily on a very recent work of Rao[12], *from population control to reproductive health,* which (as one of the reviewers noted) is a powerful history and critique of population control in India.

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[10] S. Guha, *Health and Population in South Asia* (London: Hurst and Company, 2001)., I. Habib, "Population," in *The Cambridge Economic History of India*, ed. T. Raychaudhri and I. Habib (Hyderabad: Orient Longman, 1982)., K. Davis, *The Population of India and Pakistan* (Princeton: Princeton University Press, 1951).

[11] Patel, *Fertility Behaviour.*, p. xix

[12] Mohan Rao, *From Population Control to Reproductive Health : Malthusian Arithmetic* (New Delhi ; London: Sage, 2004).

Pre-Malthusian Prescriptions

Unlike the present day population growth puzzle, there was also a time when population growth was symbolic of nation's robustness. For example, French intellectuals of eighteen century pondered over the scarce population of their country and large population and imperial might of England.[13] Montesquieu was one of the most influential writers on the population question at this time. His work *Lettres Persanes,* published in 1721, made a profound impact on Enlightenment thinkers. In his view, 'the French nation was degenerate and the population, therefore declining' and further comparing the contemporary France to a supposedly populous ancient Greece, he argued that 'a government must be concerned with increasing the population through the provision of employment. This coupled with political liberty led, in his view, to the wealth of a nation.'[14] Further on population dynamics, Marquis de Mirabeau, the author of *The Friends of Mankind,* or Treatise on population (1756), argued, 'population was one of the essential requirements for economic growth and that the function of state policy should be to induce population growth.'[15] Furthermore, the population growth was even taken as a yardstick for good governance. For example Jean-Jacques Rousseau in *Du Contrat Social* (1962) wrote, 'the rest being equal, the government under which, without external aids, without naturalisation or colonies, the citizens increase and multiply most

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[13] George Vigarello, *Concepts of Cleanliness: Changing Attitudes in France since the Middle Ages* (Cambrige: Cambidge University Press, 1990)., p. 33. cited in Rao, *From Population Control to Reproductive Health : Malthusian Arithmetic.*, p. 76.

[14] Cited in Rao, *From Population Control to Reproductive Health : Malthusian Arithmetic.*, p. 76.

[15] Cited in Ibid., p. 76.

is beyond question the best.'[16] By the late eighteenth century, however, the perception of the population question had altered fundamentally. The reasons for this shift in the perception are enormously complex and are to be sought in the socio-economic milieu of those turbulent times.[17] Here onwards, Malthus among other contemporaries/ predecessors emerged as historical actor to reshape views on population growth.

Malthusian Prognosis

Malthus became immortal with the publication of his masterpiece *An Essay on the Principle of Population as It Affects the Future Improvement of Society with Remarks on the Speculations of Mr. Godwin, M. Condorcet and Other Writers* in 1798. He forwarded two basic propositions: 'First, that food is necessary to the existence of man. Secondly, that the passion between the sexes is necessary and will remain nearly in its present state.'[18] According to Rao, Malthus went to write 'one of the most famous, or notorious, passages in the social science' and that:

> Assuming my postulates as granted, I say, that the power of population is indefinitely greater than the power in the earth to produce subsistence of man. *Population, when unchecked, increases in a geometric ratio. Subsistence increases only in an arithmetic ratio.* A slight acquaintance with numbers will show

[16] Cited in Ibid., p. 76.

[17] Ibid., p. 78.

[18] T.R. Malthus, *An Essay on the Principle of Population and a Summary View of the Principle of Population* (Harmondsworth: Penguin, 1970)., p. 13. cited in Rao, *From Population Control to Reproductive Health : Malthusian Arithmetic.*, p. 79.

the immensity of the first power in comparison of the second [italics mine].[19]

With this prognosis, Malthus delineated the counter checks and noted when numbers grow beyond that point, the growth of population is halted by the two means; one he called the positive checks, that is, hunger, famines, and pestilence; and the other, preventive checks, that is, a foresight of the difficulties attending the rearing of a family acts as a preventive check. The former inevitably and 'naturally', fall on the lower classes of society. To attempt to raise the standard of living of the lower classes by increasing wages would, through the operation of the law of nature, be render ineffectual. Their population would then only increase further, till checked by a subsistence crisis. Rao noted thus emerges an iron law of wages: the subsistence wage is the just wage, because if wages are higher, population growth occurs till checked by poverty.[20] Poverty, then, was 'seen as a natural condition of human existence and not as a product of human institutions. The role of the poor was to accept misery for 'the misery that checks population falls chiefly, as it always must do, upon that part whose conditions is lowest in the scale of society. The rich are in no way responsible for poverty; they are enjoined not to exert themselves to do something about it for no possible contributions or sacrifices of the rich, particularly in money, could for any time prevent the recurrence of distress among the lower members of society.'[21] Malthus was also very forthright in his view: 'the truth is that the pressure of distress on this

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[19] Malthus, *An Essay on the Principle of Population and a Summary View of the Principle of Population.*, p. 16. cited in Rao, *From Population Control to Reproductive Health : Malthusian Arithmetic.*, p. 79.

[20] Rao, *From Population Control to Reproductive Health : Malthusian Arithmetic.*, pp. 79-80.

[21] Cited in Ibid., p. 80.

part of the community (viz. the lower classes) is an evil so deeply seated that no human ingenuity can reach it.'[22] In the second edition of his essay in 1803 he even argued that the poor have no moral right to relief.[23] Amartya Sen[24] drawing attention to the pessimism in Malthus as opposed to reason optimism in Condorcet, points out that:

> The difference in approach between these thinkers on the population question becomes even more apparent when we think of solutions. Condorcet would thus call for the absence of Malthusian fatalism, and the willingness to look for solutions to difficult social problems, rather than accepting the inevitability of misery. This would also mean a rational search for the effectiveness of alternative social and economic policies. Above all, it would mean keeping faith in the voluntary, reasoned, decisions of people rather than any element of compulsion in decisions involving fertility.

Rao also lashes on Malthusian premises and argued, 'the major propositions, or assumptions, that population when unchecked grows in a geometric ratio while food can grow only in an arithmetic ratio, *the foundation of the Malthusian edifice, are, in fact, entirely arbitrary.* It is on the basis of these arbitrary propositions that the entirely complex issue of the relationship between resources and population is examined [italics mine].'[25] He further noted 'the nineteenth century English experience of a surge in population

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[22] Cited in Ibid., p. 81.

[23] Cited in Ibid., p. 82.

[24] Amartya Sen, "Population and Reasoned Agency: Food, Fertility and Economic Development," in *Population, Economic Development and Environment*, ed. K. L. Kiessling and H. Landberg (New Delhi: Oxford University Press, 1994).

[25] Rao, *From Population Control to Reproductive Health : Malthusian Arithmetic.*, p. 85.

accompanied by rising per capita income, discredited the ideas of Malthus. As England completed her industrial and health revolutions, and as birth rates subsequently commenced a secular decline, Malthusianism lost its bite, its urgency, its pungency. It was not, however, put to deserved rest. *It continued to be resurrected as an explanation of poverty in other parts of the world* [italics mine].'[26] Rao's assertion will get more weight as the next few paragraphs of this sub-chapter briefly dwells on the 'new *avatars*' of Malthus- eugenics, birth controllers and the true 'heir' neo-Malthusians.

Eugenics Quest and Debacle

Like Malthus *Essay*, there is another classic that is, *Descent of Man* by Charles Darwin (published in 1871). Darwin's enunciation of the principle of *survival of the fittest* has inspired (both positively and negatively) many movements, of which, eugenics movement was no exception. Like the two fold Malthusian propositions, the eugenics had as their prime concerns- '*racial purity and improvement of the racial stock*'[27] [italics mine]. The eugenics movement was named by one of its illustrious founders, a cousin of Darwin's, Francis Galton. Galton inaugurated the Eugenics Educational Society and brought out a journal called *Eugenics Review*. He was also responsible for the founding of the biometric laboratory at the University College, London and its journal *Biometrica.* Rao noted, 'Galton's passion was the application of statistics to data on genealogies and the collection of data on the lineage of the pedigreed. *He was firmly committed to the idea that only the bright and best should be*

[26] Ibid., p. 90.

[27] Ibid., p. 93.

encouraged to breed [italics mine].'[28] Jane Hume Clapperton published the principal text of the eugenics, *Scientific Meliorism* in 1885. She went to write:

> The racial blood shall not be poisoned by moral disease. The guardians of social life in the present day dare not be careless of the happiness of coming generations; therefore the criminal is forcibly restrained from perpetuating vicious breed.....To promote the contentment of congenital criminals within their prison home, where they are detained for life, an alternative to celibacy might be offered, viz. a surgical operation rendering the male sex incapable of reproduction.[29]

Given the overwhelming influence of Darwin (indeed the age is frequently referred to as the age of Darwin), it is not surprising that many commentators of this time introduced Darwinian metaphors to social arrangements. Social Darwinists, believing that biology was destiny, at least for the poor, thus began to identify an extraordinary series of social and of behavioural facts as inheritable. It was not far from this to asserting that only 'fit' should be encouraged to procreate and that the 'unfit' discouraged.[30] This wave of thoughts did also attract Adolf Hitler. His cabinet promulgated a Eugenic Sterilisation Law in 1933 to 'prevent poisoning the entire bloodstream of the race.'[31] Soon eugenic policies merged with racial policies resulting into Hitler's horrible final solution. However, precedent for eugenic laws in Germany had in fact, been set in the US. Dr. Harry C. Sharp, physician to the Indiana State Reformatory in 1899 pioneered the sterilisation of the unfit by

[28] Ibid., p. 93.

[29] Cited in Ibid., p. 93.

[30] Cited in Ibid., p. 94.

[31] Cited in Ibid., p. 95.

vasectomy. The first state to pass sterilisation laws was Indiana in 1907. Eugenics were scientifically discredited by that famous biologist J.B.S. Haldane. But it was Herman Muller's discovery of mutation in the early 1940 that demanded it of the very last vestiges of scientific respectability. The eugenic lobby now turned to what they called crypto-eugenics or population control.[32] It may be added that eugenics having also been maligned due to the 'final solution' went underground and disguised themselves to be reborn as the propagators of birth control movement.

Birth Control Movements

It is rightly noted that various streams of thought jostling uneasily with one another, congealed, into the birth control movement in the nineteen-century gathering strength in the early twentieth century.[33] Rao tracked four such major streams.[34] One stream was that of the *radical feminists*, tracing their descent in modern times to Marry Wollstonecraft's publication in 1792 of *The Vindication of the Rights of Women*. These persons believed, and believed strongly, that it was women's right to control their own destinies, their own bodies. Access to birth control, then banned, was one element in their larger struggle for democratic rights. The second stream was that of the *socialists*. Their ideas on birth control were coloured by the feeling that the burden of repeated pregnancies was harmful to the health of working women; and by the belief that it was in the interests of capitalists, who needed on unlimited supply of cheap labour, and not of the working class, to have large populations.

[32] Cited in Ibid., p. 99.

[33] Ibid., pp. 99-100.

[34] Ibid.

Further, on the question of Marxism *per se* and birth control B. Z. Urlanis[35] noted, 'world literature widely expresses the view that Marxism does not recognise birth control and is opposed to its practice. In fact this is not so at all.' He argues that Engle's very clearly expressed himself on this question is his letter to Kautsky dated 1st February, 1881. In this letter he wrote that if communist were ever forced to regulate the production of people.....it could do so without difficulty. Later on, in that letter Engle's reminded Kautsky that the process of birth regulation is already developed in France and lower Austria. He concluded that Soviet demographers believe that together with an economic solution there must also be a demographic solution, that is to say, a lowering of birth rates by means of an effective demographic policy. The aim of such policy must be to spread planned families, and this implies the use of birth control by the population.[36] Moreover, Marx and Engles, besides reserving a number of choice epithets for Malthus argued that there is no fixed, universal, eternal law of population. Marx noted 'social factors create a law of population peculiar to the capitalist mode of production', adding that 'in fact every particular historic mode of population has its own special laws of population, historically valid within that particular sphere.'[37] Interestingly, we are also being reminded of the dismal fact that the issue of birth control is the only one in which the Vatican and the Kremlin are in

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[35] B.Z. Urlanis, "Marxism and Birth Control," in *Studies in Demography- Essays Presented to Professor S. Chandrasekhar on His Fifty-First Birthday*, ed. Ashish Bose, P.B. Desai, and S.P. Jain (London: George Allen and Unwin, 1970)., p. 285.

[36] Ibid., pp. 287-288.

[37] Karl Marx, *Capital*, vol. I (Harmondsworth: Penguin, 1976)., pp. 783-84. Cited in Rao, *From Population Control to Reproductive Health : Malthusian Arithmetic*., p. 89.

agreement.[38] The third and important stream, which came to dominate the birth control movement, was that of the *neo- Malthusian*. Finally, the last and least significant was an offshoot of the *Romantic movement*, the free lovers who believed in the liberating powers of the sexual act which they believed should be untrammelled from its association with procreation. However, as Rao noted these contending tendencies produce certain inbuilt tension in the birth control movement. The movement was ultimately taken over by the neo-Malthusians by the 1920s.[39] Thus, neo-Malthusian ascendancy merits further discussion.

Neo Malthusians Ascendancy

The late nineteenth century witnessed the birth of a new '*avatār*' of Malthusianism, namely, neo-Malthusianism. Malthusianism and neo-Malthusianism are not conceptually or methodologically distinct. They differ in, so far as the victims of their ideas or methods are concerned. While Malthusians were concerned with the poor of their own countries, neo-Malthusians looked across the seas at the poor in developing countries. And while Malthusians spoke of moral restraint neo-Malthusians came equipped contraceptive technology.[40] Margaret Sanger, an American nurse, possibly did more than anybody else to ultimately put birth control on the world agenda. Powerful and influential, she has been described as the 'messiah of

[38] Cited in S.Chandrasekhar, *Hungry People and Empty Minds* (Baroda: M.S. University of Baroda, 1952)., p. 15.

[39] Rao, *From Population Control to Reproductive Health : Malthusian Arithmetic*., p. 100.

[40] Ibid., p. 92.

medicalised birth control.'[41] She brought out a pamphlet entitled *Family Limitation* in 1914. Her primary aim was to limit what she perceived as the excessive fertility of the poor. Large families, Sanger wrote, are associated with poverty, fighting, jails; the small ones with cleanliness, leisure, freedom, light, space, sunshine. Her most famous book was the 1920 publication *Women and the New Race,* an orthodox tract of eugenics: 'First, stop the multiplication of the unfit. This appeared the most important and greatest step towards race betterment.' She founded the American Birth Control League in 1921, a national organization for medicalised birth control. In 1925, she organised the International Neo-Malthusian and Birth Control Conference in New York bringing together leading eugenics and birth controllers and in 1927, the First World Population Conference in Geneva, which brought together American and European eugenics and Neo- Malthusians. In 1935 Sanger undertook a triumphant tour across India.[42] In 1940 Henry Pratt Fairchild, President of the American Eugenics Society, told the annual meeting of the Birth Control Federation, the new incarnation of the American Birth Control League. This momentous marriage had the financial backing of American corporate capital that had earlier supported eugenics: Gordon notes that 'in no academic field was the coalition between corporate capital and scholars developed more fully than in eugenics.'[43] It is this co-option of eugenics into birth control movement on one hand and eugenics debacle in Europe due to the Nazi's penchant 'support' for it, on the other, all attention turned to third-world countries. Thus, post- world war era witnessed huge

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[41] Ibid., p. 101.

[42] Ibid., 108.

[43] Linda Gordon, *Women's Body, Women's Right* (Harmondsworth: Penguin, 1976).

inflow of funds for population control in third world countries. However, before going into the details of population control dynamics in the third world, few words on a theory that was developed out of the decades of these movements and which, later provided justification and inspiration for the population lobbies, seem pertinent.

The edifice on which birth control movement, (more specifically neo-Malthusians) rested and took succour was the theory of demographic transition which was presented as general theory of population. Cowgill[44] has presented a brilliant sketch of how the transition theory evolved from Pearl and Reed (1920) *logistic Curve theory* to Thompson (1929) and Notestein (1945) *demographic transition model* i.e. different stages of progression through the transition: "High potential growth", "Transitional"' and "Incipient Decline". Cowgill (1963) made this implicit dynamics, explicit and noted, 'transition theory deals with two conditions of stability and one of change. It asserts that the modern growth cycle is essentially a transition from: stage 1, under which both birth and death rates are under a minimum of human control, through stage 2, the period of growth, to stage 3, under which both birth and death rates are extensively controlled and are balanced at a low level.'[45] In 1970 Cowgill warned for correlating and drawing inspiration from European demographic transition, which deserve lengthy quotation as under:

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[44] Donald O. Cowgill, "The Use of Logistic Curve and the Transition Model in Developing Nations," in *Studies in Demography- Essays Presented to Professor S. Chandrasekhar on His Fifty-First Birthday*, ed. Ashish Bose, P.B. Desai, and S.P. Jain (London: George Allen and Unwin, 1970).

[45] D.O. Cowgill, "Transition Theory as a General Population Theory," *Social Forces* XLI, no. 3 (1963)., cited in Cowgill, "The Use of Logistic Curve and the Transition Model in Developing Nations.", pp. 160-161.

The conditions in the developing countries since World War II definitely and emphatically do not parallel the experiences of the European countries on which the transition theory (and Pearls application of logistic curve) was based. Whereas it took European countries 150 to 200 years to reduce their death rate below 15, this is being done in developing countries now in 15 or 20 years. The European countries had to invent their technology of death control as they developed economically; in the developing countries today, all of this technology of death control can be imported practically overnight and this is almost literally what is happening. It took 150 to 200 years for European countries to cut their birth rates below 20. So far, there is little indication of declining fertility in developing countries, even though some of them are consciously attempting to bring this about.

If it is appropriate to call the demographic change in Europe over the last two centuries "demographic transition", it is certainly not appropriate to use the same term for what is happening in the developing countries today. A one per cent rate of increase is definitely different from a three per cent rate of increase. A fifty per cent reduction in the death rate in a hundred year is quite different from a fifty per cent reduction in ten years. What is happening in the developing countries is not a "transition"; it is, Kingsley Davis has said an "explosion". ..... *The developing nations are involved in a growth process which is entirely new in human history. They dare not rely on models developed in past centuries on the basis of European countries. They must blaze their own trails.* .....the only reasonable and rational course, under these circumstances is *to make the maximum use of the technology of birth control*, indigenous or foreign, in the effort

to bring the birth rates within economically digestible range of death rates [italics mine].[46]

Khan[47] also supports the above logic and argued that while the analysis of the demographic transition in western countries do provide us some clues to the understanding of fertility behaviour, their reasoning may not be applicable for our study (or perhaps for any study in a developing society). There are some basic differences in the social structure of western countries and Indian society (representing the developing countries). India, Talwar[48] noted, in its journey towards demographic transition has assumed a unique profile of its own because of its living pattern wherein 74 per cent of its people live in 600000 plus villages, several of them remotely located, with typical social and cultural practices. It is also argued, 'the problem of population growth in India is essentially a regional problem. The future decline in the growth rate of Indian population would largely depend on the decline in the birth rates of the major states like Uttar Pradesh, Bihar, Madhya Pradesh , Rajasthan and Haryana.'[49]

1.2 The Third World Population- dynamics of population growth, birth control and development

A. R. Desai, the renowned Indian sociologist in his brilliant critique of family planning published in 1980, made a very exhaustive survey of literature on

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[46] Cowgill, "The Use of Logistic Curve and the Transition Model in Developing Nations.", pp. 162-165.

[47] M.E. Khan, *Family Planning among Muslims in India- a Study of the Reproductive Behaviour of Muslims in an Urban Setting* (New Delhi: Manohar, 1979)., pp. 6-7.

[48] Talwar, "Determinants and Consequences of Rapid Population Growth.", p. 32.

[49] K.B. Pathak and B.S. Singh, "Fertility Transition in India," in *The Family Welfare Programme in India*, ed. Hari Mohan Mathur (New Delhi: Vikas Pub. House in association with the HCM Rajasthan State Institute of Public Administration, 1995)., p. 177.

family planning, including the changing perspectives on family planning in the developed countries, and their increasing concern for the population of third world countries, and summed the scenario as:

> From the inception, the Government of India, along with all the Third World governments, as well as the prime "aid" giving, developed imperialist countries of the First World, have assumed that the chief reason for backwardness, underdevelopment and the inability of the Third World countries to cross the threshold of take-off and become developed, prosperous societies, is the runaway population of these countries, experiencing a demographic transition, due to rapid decline in death rate not paralleled by similar decline in birth rate. "The Runaway Population", "Tidal Wave of Growing Population", "Population Bomb", "Baby Boom", "Unprecedented Trend in population increase as a dreadful mirage to the future development of the Third World" and various other catch phrases evolved to highlight the need for population control, clearly point to the central assumption of the family planning movement launched by the Government of India, along with a number of countries in the Third World. This assumption can be stated thus. Rapidly growing population is the chief obstacle to the plans of development of the Third World countries, by eating up the little available fruits of development, as well as by minimizing the "Saving" and "Investment" potential of the already "overpopulated, Third World". .....In fact, eminent theoreticians and policy makers have pointed out that first "decade of hope" viz; fifties, due to inability to control the population explosion, transformed sixties into a "decade of despair". And the third decade viz; seventies, because of still unabated population explosion is becoming a decade of tensions and social

> explosions, leading to near "Breakdown of modernisation." The situation with regard to "Population" according to the theorist of and policy makers of the First and the Third World countries, wedded to specific path of development has reached such a critical stage that the UN designated year 1974 as the World Population Year.[50]

With this account of history, Desai lashed on the "population control" objective in India and also in large number of Third World countries and argued that it liberates the government from the task of providing necessary infrastructural matrix for a family even to survive not to talk of a better and balanced life, and to perform, along with its replacement function, other functions properly.[51] He quoted J.C. Kavoori[52] who described the 'population control' as the 'sickness syndrome' for the family planning programme. However, before dwelling on the limitations of the family planning programme, which will be discussed in the later sections, let's have a wider and in-depth understanding of how the chase for wild goose (i.e. population control and development) started in third world countries in general, and India in particular.

The Third World Population- international intellectual debates, donor agencies and lobbies

Davis noted that most observers are surprised by the swiftness with which concern over the population problem has turned from intellectual analysis and

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[50] A. R. Desai, *Urban Family Planning in India* (Bombay: Popular Prakashan, 1980)., pp. 132-133.

[51] Ibid., pp. 139.

[52] J.C. Kavoori, "Reconstruction of the System," *Seminar*, no. 231 (1978)., p. 20.

debate to policy and action.[53] Much of the credit (or blame) goes to 'over supply' of money from international donor agencies that prevailed over the post- World War scenario. Demerath[54] and Hudson[55] have thoroughly pondered over the manoeuvre of these donor agencies. For example, Demerath noted with the co-option of eugenics into the population control movement, funds began flowing, initially from the Ford Foundation and Rockefeller Foundation, into demography as an academic discipline and its policy counterpart, the population control lobby. Between 1952 and 1975, the Ford Foundation spent more than $ 150 million on population control. Of this, about $ 80 million went into research and training in reproductive biology. About $ 35 million was use to finance family planning programmes. Indians received more than $20 million. Hudson has also drawn attention to establishment of Population Council by John D. Rockefeller in 1952 and thereafter much impetus to population research. For example, Population Council stated publication of journals (still the leading journals), *Studies in Family Planning,* and *Population and Development Review*. Likewise, Ford Foundation provided seed capital for *Demography*, and USAID funded publication of the *International Family Planning Perspectives*. The forthcoming paragraphs of this section will dwell on the dynamics of population control movement in pre and post independent India.

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[53] Kinglay Davis, "Population Policy: Will Current Programs Succeed?," in *Studies in Demography- Essays Presented to Professor S. Chandrasekhar on His Fifty-First Birthday*, ed. Ashish Bose, P.B. Desai, and S.P. Jain (London: George Allen and Unwin, 1970)., p. 369.

[54] Nicholas J. Demerath, *Birth Control and Foreign Policy* (New York: Harper and Row, 1976).

[55] Dennis Hodgson, "Orthodoxy and Revisionism in American Demography," *Population and Development Review* 14, no. 4 (1988).

Lobbying in Pre Independent India – responses and reactions

P.B. Desai[56] has very brilliantly outlined the history of India's population policy. He noted:

> Faint beginnings of the birth control movement can be traced to the early twenties. Beginning with the attendance of Indian representatives in the first international birth control conference in London in 1922 and the New York birth control conference in 1925, the birth control movement in India became progressively more organised until its culmination in the formation of the Family Planning Association of India[57] in 1949 (it was first christened as Family Planning Committee later in 1951 renamed to Family Planning Association of India)[58]. This Association convened the first All-India Conference on Family Planning in 1951 under the Presidentship of Professor S. Chandrasekhar and also organised in 1952 in Bombay an International Conference on Family Planning which was inaugurated by Vice-President Dr. S. Radhakrishnan. Important among the intervening events contributing to the growth of interest in family planning were: the founding of the Neo-Malthusian League in Madras in 1928; Mysore Government's step to direct State hospitals to give birth control advice in 1930 (interestingly this move of Maharaja of Mysore, became historical as '*the world's first*

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[56] P.B. Desai, "The Perspective of India's Population Policy," in *Studies in Demography-Essays Presented to Professor S. Chandrasekhar on His Fifty-First Birthday*, ed. Ashish Bose, P.B. Desai, and S.P. Jain (London: George Allen and Unwin, 1970)., pp. 400-402.

[57] Rao also noted that the FPAI (Family Planning Association of India) has been a major force shaping population policy in the country. Indeed it takes credit for playing an active note in inducing the first Planning Commission to incorporate family planning in health. Financial assistance to the FPAI is largely provided by international agencies, particularly the Rockefeller Foundation supported International Planned Parenthood Foundation (IPPF); in 1982 the FPAI received a project grant of US $ 2,782,000. See Rao, *From Population Control to Reproductive Health : Malthusian Arithmetic.*, p. 109.

[58] Additions in parenthesis are mine.

> *Government-sponsored birth control clinic*')[59]; the founding of the Family Hygiene Society and of the *Journal of Marriage Hygiene* by Pillay in 1935; the discussion of the question of birth control by the Lucknow Population Conference in 1936; the nation-wide tour of Margaret Sanger in the same year; the convening of the First Family Hygiene Conference in conjunction with the Second-All India Population Conference in 1938 (it was organised by Lady Rama Rao and Sanger)[60]; and the strong recommendation of the Health Survey and Development Committee for taking up propagation of family planning as an official responsibility.

Desai went on presenting the vivid account of lobbying by Margaret Sanger (in which she was to certain extent successful[61]) and her fruitless persuasion of Gandhi to support family planning. However, Gandhi made his position very clear, as Desai quotes him, 'there can be no two opinions about the necessity of birth control. But the only method handed down from ages past is self-control or *Brahmacharya*. It is an infallible sovereign remedy doing good to those who practice it.'[62] As a result of surcharged atmosphere, the Indian National Congress also pondered over the issue of growing population. The President of 1938 Session of Indian National Congress, Subhash Chandra Bose, pointed out in his address that 'where poverty, starvation and disease are stalking the land, we cannot afford to have our population mounting up by

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[59]Added from Rao, *From Population Control to Reproductive Health : Malthusian Arithmetic.*, p. 108. However, as individual initiatives, Karve opened the first family planning clinic in India in 1925.

[60] Self addition, it may also be noted that Lada Rama Rao was instrumental in the formation of FPAI and was its founding President. Cited from Ibid., p. 109.

[61] Rao also acknowledged the over all success of Sanger minus Mahatma Gandhi, when he writes, 'Sanger undertook a triumphant tour across India, winning friends and influencing people, although she left Mahatma Gandhi singularly unimpressed.' See Ibid., p. 108.

[62] Cited in Desai, "The Perspective of India's Population Policy.", p. 401.

thirty million during a single decade.....It will therefore be desirable to restrict our population until we are able to feed, clothe and educate those who already exists.'[63] As its President, he constituted the National Planning Committee (NPC) under the chairmanship of Pandit Jawaharlal Nehru, which considered the report of its sub-committee on population in May 1940 and adopted several resolutions two of which were- 'i) We agree with the view that the size of the Indian population is a basic issue in national economic planning, in so far as its unrestricted increase, out of proportion to means of subsistence, affects adversely the standard of living; and tends to defeat many social and ameliorative measures; and ii) In the interest of social economy, family happiness and national planning, family planning and a limitation of children are essential, and the State should adopt a policy to encourage these. It is desirable to lay stress on self-control, as well as to spread knowledge of cheap and safe methods of birth control. Birth control clinics should be established and other necessary measures taken in this behalf and to prevent the use or advertisement of harmful methods.'[64] During this period impetus also came from a strong lady, Lakshmibai Rajwade, who was very instrumental in shaping the above recommendations. Rao aptly commented on the same:

> At a time when no nation in the world sponsored a family planning programme, Lakshmibai Rajwade forcefully argued the case for the inclusion of birth control, provision of goods, instructions, demonstrations and consultations in maternal and child health services. She (Rajwade) argued birth control is

[63] Cited in Ibid., pp. 401-402.

[64] National Planning Committee., "Population: Report of the Sub- Committee," (Bombay: Vora and Co. Publishers, 1947)., pp. 144-145. Cited in Desai, "The Perspective of India's Population Policy.", pp. 401-402.

> obviously a very important function in view of the fact that the high mortality among mothers and children is in part due to too frequent pregnancies involving a terrific strain on the nerves and on vitality already abnormally low..... *The reproductive system has to be kept fresh and vitalised to respond creatively and must not therefore be subjected to that strain. That can only be done by controlling pregnancy by contraceptive methods* [italics mine].[65]

Desai rightly argued that the recommendations of the National Planning Committee were taken up in 1951, when the Congress Government of the new Republic of India introduced Central Planning as an instrument for social and economic development.'[66] In the same stream the famous Health Survey and Development Committee, eponymously and commonly known as the Bhore Committee, was established in 1943. According to Rao, the Committee recognised 'health as a right of all citizens, irrespective of their ability to pay' and that 'notwithstanding financial constraints, the state could, and ought to, invest 10 per cent of its resources on health'.[67] Further noting that declines in birth rates had not followed declines in death rates, the Committee concluded that India was indeed confronted with a population problem that could have grave consequences, as 'uncontrolled growth of population would outstrip the productive capacity of the country.'[68] Thus, on the very eve of Indian independence the ground was ready for the long series of matches to be played to curb the population growth.

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[65] Rao, *From Population Control to Reproductive Health : Malthusian Arithmetic.*, pp. 19-20.

[66] Desai, "The Perspective of India's Population Policy.", p. 401.

[67] Rao, *From Population Control to Reproductive Health : Malthusian Arithmetic.*, p. 24.

[68] Cited in Ibid., p. 24.

No less were the researches undertaken during this period. Ashish Bose[69] attempted a sketch of the moorings of population studies and shown that there was no dearth of studies on population even in pre-independent India but most of these focused on the 'relationship between population and food' and few scholars even (in early 1930s) went to extent of developing the 'theory of optimum population.'[70] As early as 1946, Chandrasekhar[71] lamented 'the air today is thick with shouts of planning.....blue prints and plans galore are offered for present post-War agriculture planning, industrial planning, educational planning and so on. While planning in all these fields is relevant and necessary *there has been no talk of specific population planning* [italics mine].'

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[69] Ashish Bose, "Demographic Research in India: 1947-1969," in *Studies in Demography-Essays Presented to Professor S. Chandrasekhar on His Fifty-First Birthday*, ed. Ashish Bose and others (London: George Allen and Unwin Ltd., 1970)., p. 31. Few of many prominent pre-independent studies, Bose examined and listed (pp. 30-34) are- P.K. Wattal, *The Population Problem in India*, (in 1934) 2nd ed. (Delhi: 1916)., Brij Narain, *The Population of India* (Lahore: Ramkrishna and sons, 1925)., Murari S. Krishnamurthi Ayyar, *Population and Birth-Control in India* (Madras,: 1930)., D.G. Karve, *Poverty and Population in India* (Bombay: Oxford University Press, 1936)., B.T. Ranadive, *The Population Problem in India* (Bombay: Longmans, 1936)., B.K. Sarkar, *The Sociology of Population* (Calcutta: 1936)., Radhakamal Mukerjee, *Food Planning for 400 Millions* (London: Macmillan, 1938)., B.N. Ganguli, *Trends of Agriculture and Population in the Ganges Valley* (London: 1938)., Gyan Chandra, *India's Teeming Millions* (London: George Allen and Unwin, 1939)., N.V. Sovani, *The Population Problem in India: A Regional Approach* (Poona: 1942)., Radhakamal Mukherjee, *The Political Economy of Population* (Bombay: 1943)., S. Chandrasekhar, *India's Population-Fact and Policy* (New York: The John Day Company, 1946)., D. Ghosh, *Pressure of Population and Economic Efficiency in India* (New Delhi: Indian Council of World Affairs, 1946).,

[70] Mukherjee, for example, wrote a series of articles. See Radhakamal Mukherjee, "Optimum and Overpopulation," *Indian Journal of Economics* X, no. 3 (1930)., Radhakamal Mukherjee, "The Criterion of Optimum Population," *The American Journal of Sociology* XXXVIII, no. 5 (1933).

[71] Chandrasekhar, *India's Population- Fact and Policy*., p.75.

Post-Independent India's Proactive Family Planning Initiatives and Donor Agencies

With the dawn of independence, the government of teeming millions with millions of problems made tryst with increasing population and launched under the "rubric of Family Planning"[72], a comprehensive multi-sided programme to control the growth rate of population, and accordingly achieved the dubious 'distinction of being the first national government in the world to adopt family planning as an integral part of its socio-economic development plans in 1952.'[73] Thus, 'from the early days a family planning programme was envisaged as an integral part of a comprehensive social development programme.'[74] In the General Report on the post-independence first Census, R. A. Gopalaswami, the Registrar General of India, sounded a note of warning that 'unless population was checked the future was indeed bleak.'[75] Before dwelling further on the problem of population growth, which today sounds more of rhetoric, it is wiser to first look at the pattern of population growth. Talwar[76] noted four distinct periods in the pattern of population growth, which deserve full quote:

> *The first is between 1901-1921 when the population remained almost stationary* with both birth and death rates at very high levels of 45 and over per 1000 population. The year of 1921 is

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[72] Desai, *Urban Family Planning in India.*, p. 125.

[73] Asok Mitra, *India's Population- Aspects of Quality and Control*, vol. II (New Delhi: Family Planning Foundation/ICSSR, 1978)., p. 633.

[74] Arvind V. Zodgekar, "Family Welfare Programme and Population Stabilization Strategies in India," *Asia-Pacific Population Journal* 11, no. 1 (1996).

[75] Census of India, "Census of India, 1951," in *Vol. I, Part-I-A Report* (Delhi: Government of India, 1953). Cited in Bose, "Studies in Demography.", p. 32.

[76] Talwar, "Determinants and Consequences of Rapid Population Growth.", pp. 35-36.

a period of great divide in the demographic history of India when mortality started to decline leading to acceleration in the rate of population growth. *The next three decades 1921-51 represent the second period of population growth in India when the rate of population growth continued at a level of over one per cent per annum*[77]. The acceleration in the rate of population growth was contributed by decline in mortality with the disappearance of plague and improved control of cholera and other infective diseases. The slight dip in growth rate in 1941-51 partly reflects the Bengal famine of 1942-43 and the dislocations due to partition of India in 1947. *The period of 1951-81 becomes the third period in the history of population growth in India.* The rate of population growth accelerated to little over two per cent per annum because of sharper declines in mortality due to the success of public heath measures in the post independence period. The period 1961-81 showed the peak rate of population growth, that is, 2.2 per cent per year. During the first decade 1961-71, only mortality declined and the rate of population growth attained a peak[78]. The second decade of this period, namely, 1971-81, showed an equal decline both in the birth rate and death rate, both balancing in such a way that the rate of population growth continued at a peak rate of about 2.2 per cent. This decade makes the turning point in the history of fertility in India, when it started declining and continued declining year after year. *The turning point in the rate of population growth is the decade 1981-91 when it declined from 2.2 per cent per annum to 2.1 per cent.* Though a welcome sign of decline in population growth rate has been noted, its pace is slow and not enough.

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[77] Also see Pravin Visaria and Leela Visaria, "India's Population," in *Handbook of Indian Sociology*, ed. Veena Das (New Delhi: Oxford University Press, 2004)., p. 66.

[78] Visaria and Visaria noted that the expected life span of an average Indian has risen markedly (although rather gradually) since Independence from about 32 to an estimated 62-63 years during 1996-2001; it represents a real gain in the welfare of the people. See Ibid., p. 66.

Talwar further noted that another feature of the growth of population in India is its absolute size of increase. Therefore though it is a feeling of satisfaction to see that the turning point in the rate of population growth has been achieved in 1981-91 but in terms of numbers we are still stuck with heavy pressure on our limited resources which are to be shared by the total number of people.[79] Visaria and Visaria rightly observed that 'the momentum for growth built into the young age distribution of India's population makes it inevitable that even if all Indian couples were to decide immediately to have no more than two children; the rate of population growth would remain positive (or above zero) for the next 50 to 60 years. However, *the size of the ultimate total population, at the time when population stabilizes, would be smaller than otherwise if the replacement level of fertility is reached sooner rather than later.* Therefore, efforts to accelerate the progress towards the replacement level of fertility certainly need to be pursued' [italics mine].[80]

The role and place of international donor agencies in India's family planning programmes rest at the upper echelons (off course, of doubtful value). It is even argued that 'it is not possible to understand the Indian Family Planning Programme without reference to the international actors who set the agenda, primarily in the United States (US).'[81] Few scholars like Mass, Demerath,

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[79] Talwar, "Determinants and Consequences of Rapid Population Growth.", p. 36.

[80] Visaria and Visaria, "India's Population.", p. 80. Else where they noted according to an analysis of the factors contributing to long-term population growth, momentum for growth is likely to account for about 58 per cent of the growth during 1991-2101 [Leela Visaria, Pravin M. Visaria, and Gujarat Institute of Development Research., *Prospective Population Growth and Policy Options for India, 1991-2101* (Ahmedabad: Gujarat Institute of Development Research, 1996).] Further according to them an ongoing exercise suggests this proportion to be higher, almost 75 per cent [L. Visaria and P. Visaria, *An Analysis of the Long-Term Population Projections for Various States of India, 1991-2101* (2000).]

[81] Rao, *From Population Control to Reproductive Health : Malthusian Arithmetic.*, p. 27.

Minkler, Hudgson, Connelly and (among Indians) Banerji, Raina, Bose and Rao have keenly observed and penned the donor driven events. Notable and persistence among this genre is Ashish Bose, and very recently Mohan Rao has also joined the rank. The works of both the scholars are extensively cited and even used as tertiary sources to comprehend the impact of international agencies on family planning programme. In 1952 the Ford Foundation's representative in India informed Prime Minister Jawaharlal Nehru that his organization considered 'India's rapid population growth a major problem and was willing to consider appropriate aid in this field.'[82] But India's family planning programme was already receiving international attention. Private international agencies rushed in with funds, consultants and technical advice. The Ford foundation also granted 9 million.[83] The Ford Foundation 'helped create two of India's major institutions involved in the family planning programme, namely, the Central Family Planning Institute, later rechristen the National Institute of Family Planning (NIFP) and the National Institute of Health Administration and Education (NIHA).'[84] Indeed, it has been argued that 'a small group men and women, in the US, many of them bankrolled by the Rockefeller Foundation, gave shape to the global population movement.'[85]

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[82] Meredith Minkler, "Consultants or Colleagues: The Role of U.S. Population Advisors in India," *Population and Development Review* 3, no. 4 (1977)., p. 404. cited in Rao, *From Population Control to Reproductive Health : Malthusian Arithmetic.*, p. 26.

[83] Bonnie Mass, "An Historical Sketch of the American Population Control Movement," *International Journal of Health Services* 4, no. 4 (1974)., pp. 651-74. cited in Rao, *From Population Control to Reproductive Health : Malthusian Arithmetic.*, p. 26.

[84] Minkler, "Consultants or Colleagues: The Role of U.S. Population Advisors in India.", p. 404. cited in Rao, *From Population Control to Reproductive Health : Malthusian Arithmetic.*, p. 26.

[85] Mathew Connelly, "Population Control in History: New Perspectives on the International Campaign to Limit Population Growth," *Comparative Study of Society and History* 45, no. 1 (2003)., p. 128. cited in Rao, *From Population Control to Reproductive Health : Malthusian Arithmetic.*, p. 27.

The post-war population control movement comprised a closely-knit group of public and private organisations including the Rockefeller Foundation, the Population Council, the Ford Foundation and the USAID, along with its counterparts in other western countries. Multilateral institutions, which followed the agenda set by these institutions at a later stage, included the United Nations Fund for Population Activities (UNFPA) and the World Bank.[86] The Second Plan treatment of population growth as an independent variable (unlike the First Plan), and economic development, the dependent one reflected a change of perspective which was 'actively being worked upon and current in the field of demography in the US during this period.'[87] Hodgson noted, on this changed perspective, that earlier efforts towards understanding so complex a phenomenon as the relationship between population dynamics and socio-economic change had undergone a transformation towards a policy prescription for Third World countries.[88] Similarly, Banerji observed the operational strategy of the family planning programme during the First Plan period was influenced by the approach of the International Planned Parenthood movement.[89] Rao noted that this was the beginning of a period in the West when a sense of doom and panic was being created with reference to the 'population bomb' ticking away in Third World countries, posing not only a threat to themselves but to the entire world.[90] In April 1963, the Director of Family Planning advised by Ford Foundation consultant, initiated a

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[86] Rao, *From Population Control to Reproductive Health : Malthusian Arithmetic.*, p. 27.

[87] Ibid., p. 29.

[88] Dennis Hodgson, "Demography as Social Science and Policy Science," *Population and Development Review* 9, no. 1 (1983)., p. 20.

[89] D. Benerji, "Forcible Sterilization in Family Planning," *Economic and Political Weekly* XI, no. 18 (1976)., p. 665.

[90] Rao, *From Population Control to Reproductive Health : Malthusian Arithmetic.*, p. 31.

reorganisation.[91] Even the shift from the passive clinical approach to the more active extension approach emanated from the community development movement in the US.[92] The Report of the First Mission commended the intra-uterine device for it 'offers at present the best possibilities for large scale, successful programmes for reducing the birth rate in the country. The plastic loop convinced the Mission that every effort would be made to distribute it in a wide scale.'[93] This role of the UN Family Planning Mission in 'endorsing' the loop was knowledge in the Report of the Second Mission. According to Rao, what is curious is that although the proportion of finances from international donors has never been significant- never, ever, exceeding a tenth of the total health budget, they have exerted a disproportionate share of influence.[94] The greatest foreign involvement came after the droughts and economic crises of 1966 when the World Bank pressurised the Indian Government to intensify population control measure and the USAID replaced the Ford Foundation as the leading agency providing assistance to population control in India.[95] In April 1966, the Department of Family Planning was constituted as a separate department in the Ministry of Health, Government of India. It is argued that this was done primarily to impress the World Bank and other aid agencies with a view to obtaining greater financial support.[96] Rao

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[91] Demerath, *Birth Control and Foreign Policy.*

[92] D. Banerji, *Health and Family Planning Services in India: An Epidemiological, Socio-Cultural and Political Analysis and a Perspective* (New Delhi: Lok Paksh, 1985).

[93] UN, "An Evaluation of the Family Planning Programme of Government of India," (New York: United Nations, 1969)., p. 90. Cited in Rao, *From Population Control to Reproductive Health : Malthusian Arithmetic.*, p. 33.

[94] Rao, *From Population Control to Reproductive Health : Malthusian Arithmetic.*, p. 35

[95] Oscar Harkavy, *Curbing Population Growth: An Insider's Perspective on the Population Movement* (New York: Plenum, 1995).

[96] B.L. Raina, *Population Policy* (Delhi: B.R. Publishing, 1988)., p. 71.

noted that even the de-linking of Maternal and Child Health (MCH) activities from family planning was done on the recommendation of First UN Advisory Mission of 1966 that the Department of Family Planning should be relieved from other responsibilities such a maternal and child health and nutrition.[97] Similarly, the World Bank, the UNFPA, and Swedish International Development Agency (SIDA) supported the 'dynamic' initiatives (of Earnakulam Collector on historic vasectomy targets) with considerable funds.[98] In addition to these initiatives, the GOI, in collaboration with the USAID launched the Intensive District Programme in the 46 populous districts in the country.[99] Rao also dwelled on the market lobbies and observed that 'it was well known that authorities in the USA and the UK were under tremendous pressure both from the manufactures of these drugs and the international population control establishment to licence them for use. This would enable the use of these contraceptives in the Third World, circumventing the accusation that they were being promoted in other countries.'[100] Further, Ashish Bose observations are more critical, sharp and prescriptive. When family planning 'red triangle' was at its zenith, Bose described its three sides as- massive Indian inertia, obsolete British bureaucratic procedures and fancy American ideas, which he argued even hold good today.[101] In a note to Planning Commission in 1979 Ashish Bose stated that 'the family planning programme must become wholly an Indian programme. It is unfortunate that ever since the programme was launched by

[97] Rao, *From Population Control to Reproductive Health : Malthusian Arithmetic.*, p. 37.

[98] Ibid., p. 40.

[99] Ibid., p. 41.

[100] Ibid., p. 57.

[101] Bose, *From Population to People.*, p. xxxvi.

the Government of India in 1952, foreign influence, funds and expertise have confused the situation instead of strengthening the programme.'[102] He further argued that 'our family planning programme must respect human dignity and Indian values, the sacred institution of marriage and the solidarity of the family and not preach mindless consumerism and selfish individualism to our masses.'[103] He went on to argue that 'we have perceived the population problem largely through western eyes. Right from the beginning, India's family planning programme has been heavily influenced by foreign funding agencies and foreign experts of doubtful calibre.'[104] 'The issues raised do not concern money as much as they concern policies. The whole orientation was foreign and showed colossal ignorance of the Indian social context. The vulgar advertising approach did not take into account Indian values and the respect which the institution of marriage and family life enjoyed in the eyes of millions of people.'[105] Bose even went to extent of saying that 'the role of intellectual prostitution, and out-right corruption in our family planning movement under foreign inspiration has yet to be understood by the people at large.'[106] In the second volume of his *From Population to People*, Bose even devoted a full chapter on "Foreign Aided Health and Family Planning Projects"[107] and questioned 'how is that in spite of the small investment made by the foreign agencies, our health and family planning programme get

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[102] Cited in Ibid., p. xxxvi.

[103] *Ibid.*, p. xlix.

[104] Ibid., p. 4.

[105] Ibid., p. 5.

[106] Ibid., p. 42.

[107] In Chapter 9 of this book Bose examined (as a case study) the foreign aided health and family planning projects in India. See Ashish Bose, *From Population to People*, 2 vols., vol. II (Delhi: B.R. Publishing Corp., 1988)., pp. 337-349.

hooked to these agencies so significantly and overwhelmingly? Why is there a total dependence on foreign agencies in terms of any new idea, any new slogan or any new innovation?'[108] Very recently Ashish Bose laments, I am tired of commenting on foreign '*kubuddhī*' (bad advice) which has vitiated our family planning programme.[109] He further argues that one need not be a cynic to say that a lot of market research is going on in the name of population and health surveys. Innocent demographers have yet to comprehend this new phenomenon. RCH and HIV/AIDS bring instant money but how about some solid social science research.[110] On the usage of term 'unmet need' and NFHS making it 'fashionable' Bose commented that this term smacks of what I would call 'market demography', the basic objective being calculating the demand for contraceptives to be supplied to India's teeming millions by the western countries.'[111] Bose even said that 'donors have pumped in big money which has only pampered demographers and statisticians and made them greedy instead of scholarly researchers fascinated by the data.'[112] Nicholas J. Demerath, an American sociologist who has worked as a family planning expert in India in the 1960s, and wrote a critique in 1976 in a book which, as Bose observed, thanks to the powerful international birth control lobby, hardly received any attention in India or the US. Demerath devotes a whole chapter on why family planning fails in poor countries? He observed that 'the first reason why family planning fails in poor countries is the obsession of the

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[108] Ibid., xlii.

[109] Bose, *Beyond Demography- Dialogue with People.*, p. 149.

[110] Ibid., pp. 200-201.

[111] Ibid., p. 203.

[112] Ashish Bose, "Demographic Data- Overflow and Non-Utilization," *Economic and Political Weekly* XXXVI, no. 44 (2001)., p. 4176.

experts with techniques of contraception. The belief that just about any problem can and will be fixed by some new tool or technique is as Anglo-American as apple-pie.'[113] However, the revised report of Ministry of Health and Family Welfare dated November, 2000 warmly acknowledges the donor agencies added projects (and this expected from a government report). The report noted:

> Area Development Projects are being implemented with the financial assistance from World Bank and other donor agencies for strengthening health and family welfare infrastructure in the States and reducing morbidity and birth rate and to increase the couple protection rate. These projects also have components for upgrading the skills of concerned manpower through training and for better programme management with the aim of reducing maternal and child mortality. Currently, 7 Area Projects are being implemented in 15 States and NCT of Delhi at a total cost of Rs. 1127.36 crores. The assistance in the case of UNFPA (United Nations Fund for Population Activities), DANIDA (Danish International Development Assistance), and DFID (Department for International Development, UK), is in the form of grant amounting to 100 per cent, 85 per cent and 75 per cent respectively of the total project cost, while the assistance in respect of World Bank projects is in the form of interest-free loans.[114]

It is also noted that there is a large project in Uttar Pradesh, which is assisted by USAID. It has an outlay of US $ 225 million, over a 10 year period 1992-

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[113] Demerath, *Birth Control and Foreign Policy.*, p. 90. Cited in Bose, *From Population to People.*, pp. 7-8.

[114] GOI., "National Family Welfare Programme," in *Major schemes and programmes*, ed. Ministry of Health and Family Welfare (New Delhi: Department of Family Welfare, MOHFW, GOI, 2000)., p. 164.

2002. It aims at reducing total fertility rate from 5.4 to 4.0 and increasing Couple Protection Rate from 35 per cent to 50 per cent over the project period.[115] Interestingly, up to March 31, 2000 the CPR in UP was only 38.0 per cent.[116]

1.3 Locating India's Family Welfare Programmes in Five Year Plans- shifting focus, accelerating funds and changing paradigms

India has the distinction of being the first country in the world to have an official family planning policy and programme.[117] In India, as in many developing countries, the family planning programme is the most direct public policy measure initiated to reduce the population growth rate, and ever 'since the formal beginning of the programme in the early 1950s, it has gone through many structural, administrative and implementation strategy changes.'[118] The family planning programme, now family welfare programme, kept on shifting its focus sometimes as a sub-set of health, sometimes as interesting-set with health and also a time came when family planning programme was not only parallel to health but superseded it with the huge inflow of funds[119] for family planning. Similarly, the approaches kept on changing from typical clinical to extension education and then an era of 'targets' forcing the scholars to

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[115] Ibid., p. 165.

[116] Ibid., p. 177.

[117] Demerath, *Birth Control and Foreign Policy.* Cited in Rao, *From Population Control to Reproductive Health : Malthusian Arithmetic.*, p. 25.

[118] Zodgekar, "Family Welfare Programme and Population Stabilization Strategies in India.", pp. 6-7.

[119] Mitra rightly observed that unlike major investment to sectors of economy.....*family planning was not plagued by lack of outlay* [italics mine]. See his Mitra, *India's Population- Aspects of Quality and Control.*, p. 639; more interesting are the accounts of Rao, *From Population Control to Reproductive Health : Malthusian Arithmetic.*, pp. 19-70.

conclude that 'the target has become an end in itself and not the means to bring about a decline in the birth rate'.[120] In wake of ICPD came the rhetoric for client centred target free approach and more comprehensive reproductive health. A close scrutiny of each Five Year Plan will crystallise the changing facets of the world's first officially launched family planning programme.

First Five-Year Plan (1951-56)

The First Five Year Plan acknowledged the serious 'economic consequences of high fertility'[121] and for family planning the allotment of a modest budget of Rs. 6.5 million was made.[122] It viewed 'the rapid growth of population as a source more of embarrassment than of help to development planning.'[123] 'The need for birth control was presented primarily in terms of concern for the health and welfare of families and their individual members. At that time planners in India had good reason to proceed cautiously in inaugurating a population policy aimed at reducing fertility, because virtually nothing was

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[120] Ashish Bose, "In Search of a New Strategy for Family Planning in India," in *Population Planning in India: Policy Issues and Research Priorities*, ed. A. Bose and P.B. Desai (Delhi: B.R. Publishing Corp, 1989). Also see Bose, *From Population to People*, B.L. Raina, *The Population Challenge* (Delhi: B.R. Publishing Corp, 1994), Zodgekar, "Family Welfare Programme and Population Stabilization Strategies in India." More recently Bose came heavily on the 'gang of target chasers and described this disease as ***targetitis***. See Bose, "The Family Welfare Programme in India: Changing Paradigm.", pp. 8.

[121] First Plan noted in '.....in short run, there is no doubt that given *a situation in which shortage of capital equipment rather than labour is the main limiting factor in development*, a rapidly growing *population is apt to become a source of embarrassment than of help* to a programme of raising standard of living. In other words, *the higher the rate of increase of population, the larger is likely to be the effort needed to raise per capita living standard* [italics mine].' See Asok Mitra, "Population in India's Development," in *Population in India's Development- 1947-2000*, ed. Ashish Bose, et al. (Delhi: Vikas, 1974)., p.5. Also of interest are other articles in the volume Ashish Bose et al., eds., *Population in India's Development - 1947-2000* (Delhi: Vikas, 1974). Equally vivid is the Desai account of first four plans, see his Desai, "The Perspective of India's Population Policy.", pp. 405-416.

[122] Cited in Rao, *From Population Control to Reproductive Health : Malthusian Arithmetic.*, p. 25.

[123] Cited in Desai, "The Perspective of India's Population Policy.", p. 405.

known about the attitudes of the masses or the views of religious and other leaders.'[124] The First Plan further added, 'the pressure of population in India is already so high that a reduction in the rate of growth must be regarded as a major desideratum. To some extent, improvement in living standards and more widespread education, especially among women, will themselves tend to lower the rate. But positive measures are also necessary for inculcation of the need and techniques of family planning.'[125] Ashish Bose[126] rightly observed that the First Five Year Plan 'clearly recognized the need for population control.' In fact, the Plan listed under the family planning programme the following- 'study of inter-relationships between economic, social and population changes. The information obtained by such studies will form the necessary background for the formulation of a national population policy and the development of appropriate measures for population planning based on factual information.'[127] It may be recalled that the plan forcefully put forward the MCH (Maternal and Child Health) approach and family planning was a subset of health.[128] Similarly, it is being argued that during the first decade of its existence, family planning was considered more a mechanism to improve the health of mothers and children than a method of population control.[129]

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[124] Zodgekar, "Family Welfare Programme and Population Stabilization Strategies in India.", p. 5.

[125] GOI, "First Five Year Plan," (New Delhi: Planning Commission, Government of India (GOI), 1952)., p. 18. Cited in Rao, *From Population Control to Reproductive Health : Malthusian Arithmetic*., p. 25.

[126] Bose, "Studies in Demography.", p. 23.

[127] GOI, "First Five Year Plan.", p.524. Cited in Bose, "Studies in Demography.", pp. 21-23.

[128] Bose, "Demographic Data- Overflow and Non-Utilization.", p. 4176.

[129] Shireen J. Jejeebhoy et al., "Setting the Stage," in *Looking Back, Looking Forward : A Profile of Sexual and Reproductive Health in India*, ed. Shireen J. Jejeebhoy (Jaipur and New Delhi: Rawat publication and Population Council, 2004)., p. 11; L. Visaria, "From Contraceptive Targets to Informed Choices: The Indian Experience," in *Women's Reproductive Health in India*, ed. R. Ramasubban and S.J. Jejeebhoy (Jaipur: Rawat

Thus in the First Plan, as Rao rightly noted, the perspective was evidently one that envisaged demographic changes as dependent variables, responding to wide-ranging shift in social structural factors.'[130]

Second Five-Year Plan (1956-60)

The Second Plan taking into cognisance, the diagnosis (of population problem) in the First Plan, came with prescriptive assumption viz. curb on population growth as vital for economic development.[131] The Plan noted:

> The logic of facts is unmistakable and there is no doubt that under the conditions prevailing in countries like India, a high rate of population growth is bound to affect adversely the rate of economic advance and living standards per capita. Given the overall shortage of land and of capital equipment relatively to population as in India the conclusion is inescapable that *the effective curb on population growth is an important condition for rapid improvement in incomes and in levels of living.* This is particularly so, if one bears in mind that the effects of improvements in public health and in the control of diseases and epidemics is to bring about an almost immediate increase in survival rates. While there may be differences as to the likely rates of population growth over the next 20 to 25 years, indications clearly are that even the utmost efforts which can be made- and has to be made- at this stage to bring down birth

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Publication, 2000)., P. Visaria and V. Chari, "India's Population Policy and Family Planning Programme: Yesterday, Today and Tomarrow," in *Do Population Policies Matters? Fertility and Politics in Egypt, India, Kenya and Mexico*, ed. A. Jain (New Delhi: Population Council, 1998).

[130] Rao, *From Population Control to Reproductive Health : Malthusian Arithmetic.*, p. 28.

[131] The same assumptions, Desai observed, further acquired more articulate and assertive tone from the Third Five Year Plan and acquires harsher shrillness in the Fourth and the Fifth Plans. (see Desai, *Urban Family Planning in India.*, pp. 134-135).

> rates, population pressure is likely to become more acute in the coming years. This highlights the need for a large and active programme aimed at restraining population growth, even as it reinforces the case for a massive developmental effort [italics mine].[132]

In this Plan, family planning was allotted Rs. 50 million while health was allotted a budget of Rs. 2.25 billion, out of a total plan outlay of Rs. 46.72 billion. This represented 0.10 and 4.81 per cent respectively of the Plan outlay for family planning and health.[133] By the Second Plan, according to Rao, 'the institutional structure for a separate, and powerful, vertical programme was established.'[134] The landmark being establishment of Central Family Planning Board, setting of State Family Planning Committees, commencement of contraceptive research at Mumbai, Calcutta, and Lucknow; setting of a Demographic Training and Research Centre at Mumbai along with regional centres; mobilisation of doctors, nurses and even school teachers and marked increase in rural and urban clinics.[135] On the Plan population perceptive, Rao noted, 'the Second Plan appeared to indicate that population growth was an independent variable and economic development the dependent one,

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[132] GOI, "Second Five Year Plan," (New Delhi: Planning Commision, Government of India (GOI), 1956)., p. 7. Cited in Mitra, "Population in India's Development.", p. 6; Desai, "The Perspective of India's Population Policy.", p. 405.; Desai, *Urban Family Planning in India,* Rao, *From Population Control to Reproductive Health : Malthusian Arithmetic.*, pp. 27-28.

[133] Cited in Rao, *From Population Control to Reproductive Health : Malthusian Arithmetic.*, p. 29.

[134] Ibid., p. 29.

[135] For more detail and elaborate discussion see Bose, "Studies in Demography.", pp. 23-25; Rao, *From Population Control to Reproductive Health : Malthusian Arithmetic.*, pp. 29-30.

overturning a perspective that emerged out of years of' of demographic research.'[136]

Third Five-Year Plan (1961-65)

The Third Five Year Plan document heralded with the following statement which Asok Mitra remarks as "historic statement":

> A large part of the increase in output is absorbed by the growth of population. Improvement in conditions of health and sanitation will further lower the death rate, especially the rate of infant mortality, and may for a time even tend to raise the birth rate. *The objective of stabilizing the growth of population over a reasonable period must therefore be at the very centre of planned development.* In this context, the greatest stress has to be placed in the Third and subsequent Five Year Plans on the programme of family planning. This will involve intensive education, provision of facilities and advice on the largest scale possible and widespread popular effort in every rural and urban community [italics mine].[137]

The outlay for family planning in the Third Plan was 0.5 billion: health obtained an outlay of Rs. 3.42 billion.[138] Rao argued the emphasis on the family planning programme as the centre of planned development received impetus from the results of the 1961 Census which showed a high rate of

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[136] Rao, *From Population Control to Reproductive Health : Malthusian Arithmetic.*, pp. 28-29.

[137] GOI, "Third Five Year Plan," (New Delhi: Planning Commission, Government of India (GOI), 1961). Cited in Mitra, "Population in India's Development.", p. 7., Rao, *From Population Control to Reproductive Health : Malthusian Arithmetic.*, p. 31. Also see Mitra, *India's Population- Aspects of Quality and Control.*, pp. 634-635. The third plan objective of population stabilization is much quoted and commented upon by scholars, see for example Desai, "The Perspective of India's Population Policy.", p. 405.

[138] Rao, *From Population Control to Reproductive Health : Malthusian Arithmetic.*, p. 32.

population growth than expected.[139] No less provoking was the recommendation of the Health Survey and Planning Committee, popularly known as Mudaliar Committee (in 1961) that- 'if the family planning movement is to produce early and effective results, it has to be in the nature of a mass movement' [italics mine].[140] Rao assessing the approaches in Plans noted, 'the limitations of the clinical approach were now being highlighted. The reorganised programme was to emphasise extension education, greater availability of contraceptive supplies, and less dependence on the traditional clinic approach. The result was massive expansion of the programme organisation.'[141] However, 'as steps were being initiated to implement the recognized programme, the United Nations Advisory Mission visited India in 1965 and suggested the launch of a "reinforced programme" parallel to the former. Three courses of action were recommended under the reinforced programme, namely, an energetic loop (IUCD) programme, an intensified sterilisation programme, and the promotion of the use of condoms through wider availability via commercial channels. *These recommendations shifted the focus from the reorganised programme with an extension education approach, to a forceful loop programme* [italics mine].'[142] Thus 'the Plan

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[139] Ibid., p. 32.

[140] GOI, "Report of the Health Survey and Planning Committee," (New Delhi: Planning Commission, Government of India (GOI), 1961)., p. 675. Cited in Rao, *From Population Control to Reproductive Health : Malthusian Arithmetic.*, p. 30. Further a supplement to this report (Minority Report) recommended the consideration of 'appropriate legislative and administrative measures' in view of the urgency of the problem, to ensure a fall in the birth rate of the country during the next five years. Thus, the Minority Report, Rao observed, foreboded in a sense, the shape of things to come: the iron hand of coercion behind the velvet glove of rhetoric; pp. 30-31.

[141] Rao, *From Population Control to Reproductive Health : Malthusian Arithmetic.*, p. 32.

[142] Raina, *Population Policy.*, p. 65.

witnessed IUD programme on mass level in 1965'[143] but very soon proved to be a failure.[144] The closing years of the plan also witnessed 'completion of the reorganization of administrative set-up' as a result of which 'the process of intensification of the family planning programme was pursued during the Fourth Plan with greater vigour.'[145] Visaria and Chari noted the Third Plan marked a subtle shift in programme emphasis, from the welfare of women and children to the macro objective of population stabilisation.[146] Rao concluded, 'the Third Plan period witnessed the burgeoning of the family planning programme even as it showed several shifts of policy, strategy, and emphasis. Family planning came to dominate concerns in the field of health and increasingly contoured the directions of health policy.'[147]

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[143] Sarah Israel noted in the history of family planning work in India, 1965 will be remembered as the year in which the Intra-uterine Device programme was launched as a mass drive all over the country. This was the year in which monthly insertions reached their peak and the States vied with each other to earn the much coveted Inter-State Award. See Sarah Israel, "An Assessment of the Lippes Loop," in *Studies in Demography- Essays Presented to Professor S. Chandrasekhar on His Fifty-First Birthday*, ed. Ashish Bose, P.B. Desai, and S.P. Jain (London: George Allen and Unwin, 1970)., p. 332.

[144] Rao noted in 1966-67, over 900000 women were fitted with IUCDs. In the following year, the number declined to 669000 in spite of the best of efforts, on the part of health care workers, and from then on the decline was quite drastic. In other words, the IUCD strategy proved to be a failure. See Rao, *From Population Control to Reproductive Health : Malthusian Arithmetic.*, p. 37.

[145] Desai, "The Perspective of India's Population Policy.", p. 415. Desai gave the examples of the reorganization of administrative set-up viz.-appointment of a Commissioner of Family Planning and number of Regional Directors, establishment of an autonomous Central Family Planning Institute, constitution of high Cabinet Committee to take quick decisions and speeding up the implementation of the programme. The factories for manufacturing contraceptives were opened at Trivandrum (for condoms) and at Kanpur (for IUD). Similarly, Raina noted the revitalisation of PHC system to meet the family planning goals; see Raina, *Population Policy.*, p. 65.

[146] Visaria and Chari, "India's Population Policy and Family Planning Programme: Yesterday, Today and Tomarrow."

[147] Rao, *From Population Control to Reproductive Health : Malthusian Arithmetic.*, p. 36.

Fourth Five-Year Plan (1968-74)

The Fourth Plan was preceded by three Annual Plans[148] and formation of separate Department of Family Planning in the Ministry of Health, and most significantly, resumption of office in 1967 by Mrs. Indira Gandhi's government and the appointment of Dr. S. Chandrasekhar, leading demographer, researcher and scholar of repute, as the Minister of Health and Family Planning, Government of India.[149] The Fourth Plan discovered that the problem had in fact grown even more acute. Equally ardent was the tone of The Small Family Norm Committee which noted '*the future seems gloomy unless the nation effectively controls fertility by family planning methods* [italics mine].'[150] Thus, the Plan outline contends 'under Indian conditions, the quest for equality and dignity of man requires as its basis both a high rate of economic growth and a low rate of population increase. Even far-reaching changes in social and economic fields will not lead to a better life unless population growth is controlled. Limitation of family is an essential and

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[148] The Annual Plans (1966-69) were adopted in view of serious economic crisis due to debacle with China, consecutive bad monsoon and fall in food production. This however, Rao noted, 'was not allowed to affect the population policy. Indeed, financial allocations to the programme continued to increase.' Rather many vigorous population efforts were made for example- in 1966 Maternal and Child Health (MCH) activities were de-linked from family planning in order to enable fieldworkers to concentrate on family planning; in 1967 the Indian Council of Medical Research (ICMR) recommended the introduction of Oral Pills on a pilot basis and the Nirodh (Condom) marketing programme was launched in September 1968. See Ibid., pp. 36-37, 38.

[149] Bose, however, noted, in spite of bold attempts, made by Dr. Chandrasekhar as the Minister of Health and family Planning, the problem of making a dent on the birth rate continues to be serious (see Bose, "Studies in Demography.", p. 27). Desai observed that 'the programme gained momentum' with these two developments (see Desai, "The Perspective of India's Population Policy.", p. 417).

[150] GOI, "Small Family Norm Committee," (New Delhi: Department of Family Planning; Ministry of Health, Family Planning and Urban Development, Government of India (GOI), 1968)., p. 5.

inescapable ingredient of development.'[151] The Plan emphatically observed '*population growth thus presents a very serious challenge. It calls for a nation wide appreciation of urgency and gravity of the situation.* A strong purposeful Government policy, supported by effective programme and adequate resources of finance, men and materials is an essential condition of success [italics mine].'[152] Thus, the draft plan outlay of Rs. 3 billion was revised upwards to Rs. 3.15 billion so that the programme could be strengthened and speeded up; health obtained an outlay of Rs. 4.35 billion.[153] Further for intensifying the family planning programme, new schemes like the post-partum programme, supply of surgical equipments to hospitals, intensive district and selected area programmes, supply of vehicles at primary health centres have been included for implementation during the Fourth Plan.[154] Desai observed 'the Fourth Plan's contribution in the evolution of the policy of population control has been *to make family planning entirely a centrally sponsored programme for a period of the next ten years*, the entire expenditure being met by the Central government; and to *integrate maternity and child welfare with family planning* by providing for the implementation of the schemes of prophylaxis against nutritional anaemia for mothers and children and the nutritional programme for control of blindness caused by Vitamin 'A' deficiency among children,

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[151] GOI, "Fourth Five Plan: A Draft Outline," (New Delhi: Planning Commission, Government of India (GOI), 1969)., p. 22. Cited in Desai, "The Perspective of India's Population Policy.", p. 405.

[152] GOI, "Fourth Five Year Plan," (New Delhi: Planning Commission, Government of India (GOI), 1969). Cited in Mitra, "Population in India's Development.", p.7; Rao, *From Population Control to Reproductive Health : Malthusian Arithmetic.*, p. 38.

[153] Rao, *From Population Control to Reproductive Health : Malthusian Arithmetic.*, p. 38.

[154] GOI, "Fourth Five Year Plan.", Cited in Rao, *From Population Control to Reproductive Health : Malthusian Arithmetic.*, pp. 38-39.

through Family Welfare Planning Centres [italics mine].'[155] The Plan also proposed 'to step up the target of sterilisations and IUCD insertions and to widen the acceptance of oral and injectable contraceptives.'[156] It is argued that the family planning programme 'picked up momentum only from 1966-67 when the programme became target oriented and time bound.'[157] During this period, Rao noted, vasectomy received great official impetus. Given the failure of the IUCD approach, vasectomy came to occupy centre stage in the family planning programme.[158] That's the reason why, Second United Nations Mission to evaluate the programme was also 'deeply impressed by the Government's serious commitment to the programme and by the determination of the Government's departments involved to secure its effective implementation.'[159] Pai Panandikar has rightly noticed how the much talked (as also maligned) compulsory sterilisation of emergency period gathered momentum in the preceding years and argued that 'by the time Fourth Plan was launched the programme administrators had learnt through experience that whereas other methods of family planning were of doubtful effectiveness in terms of their adoption by the people, sterilisation was specific, sure and once for all method and therefore could be depended upon for substantive achievement. Consequently, a high reliance was placed on sterilisation for achieving the target. A new strategy employed for sterilising a

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[155] Desai, "The Perspective of India's Population Policy.", p. 416.

[156] Rao, *From Population Control to Reproductive Health : Malthusian Arithmetic.*, p. 38.

[157] Bose, *From Population to People.*, p. 142.

[158] Rao, *From Population Control to Reproductive Health : Malthusian Arithmetic.*, p. 39.

[159] United Nations, "An Evaluation of the Family Planning Programme of the Government of India," (New York: United Nations, 1969)., pp. 4-5. Cited in Desai, "The Perspective of India's Population Policy.", p. 422.

large number of people was the '*camp approach*'[160]. The entire administrative machinery of a district or *tāluka* (sub-division) was mobilised to hold sterilisation camps at different places during a year, to which a large number of people were brought from surrounding areas and sterilised on the spot.'[161] In 1972-73, 3.1 million sterilisations were performed in India, a figure exceeding the number of sterilisations achieved in previous years. Two thirds of these were performed at camps.[162] In 1971, the passing of Medical Termination of Pregnancy (MTP) Act, legalising abortion, carried out by recognised practitioners on medical grounds and among grounds for eligibility is the failure of a contraceptive device. Kartar Singh Committee[163] of the period (in 1973) felt that integration (of vertical programmes) would be economical and feasible and went on to recommend the integration of the programmes. The workers of these programmes were to be re-trained and to be designated as multi-purpose workers. The shift in strategy was witnessed at the World Population Conference in Bucharest in 1974, the Indian Minister of Health and Family Planning stated that '*development is the best contraceptive*' and observed- 'we are quite clear that fertility levels can be effectively lowered only if family planning becomes an integral part of a broader strategy

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[160] This camp approach and sterilisation as a major method for reducing the birth rate, according to A.R. Desai, acquired frenzied, compulsive features during the emergency period. See Desai, *Urban Family Planning in India.*, p. 128. Moreover this *camp approach* is credited to Mr. S.S. Krishna Kumar, Collector of Ernakulam district in Kerala, who, I may say; unlike the beaten track bureaucracy manoeuvres, pioneered, proved and added the master strategy of camp approach in the arsenal of family planning programme. Rao observed the enthusiastic Collector created a 'festive atmosphere' at the camp and the result was the 'remarkable achievement' of over 15,000 vasectomies in one month and in his second camp in July 1971 over 63000 vasectomies were performed that received a striking place in the annals of India's family planning history; see Rao, *From Population Control to Reproductive Health : Malthusian Arithmetic.*, p. 39.

[161] V. A. Pai Panandikar, "Emergency and After," *Seminar*, no. 231 Trauma of Triangle (1978)., pp. 15-16.

[162] Rao, *From Population Control to Reproductive Health : Malthusian Arithmetic.*, p. 40.

[163] Cited in Ibid., p. 42.

to deal with the problems of poverty and under development.....Population policy is thus one of the several vital instruments for securing comprehensive social development, and it cannot be effective unless certain concomitant economic policies and social programmes succeed in changing the basic determinants of fertility.'[164] However, it is noted that 'in 1974 the family planning programme has reached a state of financial and even philosophical disarray. With the total number of acceptors in 1973-74 down 27 per cent on the previous year, things looked gloomy for the programme.'[165] Rao also observed, 'towards the end of the period, it was increasingly being realised that the approach hitherto adopted had not yielded commensurate returns, indeed that the *programme had reached a cold dead end.....It seemed that almost every thing had been tried that could be tried* [italics mine].'[166]

Fifth Five-Year Plan (1975-80)

The primary objective during the Fifth Plan was 'to provide minimum public health facilities integrated with family planning and nutrition for vulnerable groups- children, pregnant women and lactating mothers.'[167] The Plan noted 'the inability to obtain the reduction in birth rate targeted in the Fourth Plan and aimed at the reduction of the birth rate by a more realistic five point by the end of the Fifth Plan period, that is, to a level of 30 per 10,000 population. To

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[164] Karan Singh, "Statement on World Population Conference, Bucharest, August 1974," (New Delhi: GOI Press, 1974)., p. 1. Cited in Rao, *From Population Control to Reproductive Health : Malthusian Arithmetic*., p. 44.

[165] Robert R. Cassen, *India: Population, Economy, Society* (Macmillan: Hong Kong, 1978)., p. 174.

[166] Rao, *From Population Control to Reproductive Health : Malthusian Arithmetic*., p. 42.

[167] GOI, "Fifth Five Year Plan," (New Delhi: Planning Commission, Government of India (GOI), 1974)., p. 241. Cited in Rao, *From Population Control to Reproductive Health : Malthusian Arithmetic*., p. 44

this end, the programme for family welfare planning was to continue to be accorded the same high priority in the Fifth Plan as it occupied in the Fourth. The strategy adopted was to increasingly integrate family planning services with those of health, MCH and nutrition.'[168] The outlay for family planning was increased to Rs. 5.16 billion, health obtained an outlay of Rs. 7.97 billion out of a total Plan allocation of Rs. 537.5 billion, representing 0.96 and 1.49 per cent of the total outlay respectively.[169] On the changing notions during the emergency, Zodgekar commented that although it is generally believed that development activities and family planning programmes are "mutually reinforcing complements" rather than "mutually exclusive", the Health Minister's policy statement of April 1976 stated, among other things, that "to wait for education and economic development to bring about a drop in fertility is not a practical solution".[170] The National Population Policy (April 1976) noted:

> With 2.4 per cent of the world's land area, India has about 15 per cent of the world's people.....Indisputably we are facing a population explosion of crisis dimension which has largely diluted the fruits of the remarkable economic progress that we have made over the last two decades. If the future of the nation is to be secured and the goal of removing poverty to be attained, the population problem will have to be treated as a top national priority and commitment. .....*The time factor*

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[168] Cited from Rao, *From Population Control to Reproductive Health : Malthusian Arithmetic.*, pp. 44-45.

[169] Ibid., p. 45.

[170] Zodgekar, "Family Welfare Programme and Population Stabilization Strategies in India.", p. 5. Interestingly, the policy statement is of the same Health Minister who clarion at Bucharest World Population Conference that *development is the best contraceptive.* Why this drastic change in approach in less than two years time?

> *is so pressing and the population growth so formidable that we have to get out of the vicious circle through a direct assault upon this problem as a national commitment*.....The question of compulsory sterilisation has been the subject of lively public debate over the few months. It is clear that the public opinion is now ready to accept much more stringent measures for family planning than before. However, the administrative and medical infrastructure in many parts of the country is still not adequate to cope with the vast implications of nation-wide compulsory sterilisation.....We are of the view that where a State legislature, in the exercise of its own powers, decides that the time is ripe and it is necessary to pass legislation for compulsory sterilisation, it may do so [italics mine].[171]

Many scholars are of opinion that this policy statement gave implicit succour to compulsory sterilisation, we will emphatically add that the policy document very explicitly showed glowing green signal for the race of compulsory sterilisation targets.[172] The argument further scores if one reviews the address, Mrs. Indira Gandhi, then Prime Minister, gave just few months preceding the policy statement of 1976. Addressing the Joint Conference of the Association of Physicians in India in January 1976, Mrs. Gandhi stated- 'we must now act decisively and bring down the birth rate. *We should not hesitate to take steps which might be described as drastic. Some personal rights have to be held in abeyance for the human rights of the nation*: the right to live, the right to

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[171] Excerpts from National Population Policy: 16 April 1976. Cited from Bose, *From Population to People.*, pp. 538-544 (appendix-V)

[172] Bose called this sterilisation by hook or crook as a SHOCK therapy. See Bose, *From Population to People.*, p. xliv.

progress [italics mine].'[173] Even, 'family planning performance became one of the criteria for financial allocations; 8 per cent of central aid to states was linked to their performance in family planning.'[174] The Shah Commission noted:

> It is thus not surprising then that sterilisations were performed with new zeal in this atmosphere. Targets for sterilisation were set.....The states vied with each other to achieve the targets set. Indeed, these targets were raised to high levels by a number of state governments when chief ministers sought to ingratiate themselves with the powers that be at the Centre. Some states doubled their targets (e.g. Bihar and Maharastra), other tripled their targets (e.g. Madhya Pradesh and Himachal Pradesh), still others, more enthusiastic, quadrupled it (e.g. UP and West Bengal) and the state like Punjab increased its targets by five times.[175]

Indeed, the Joint Secretary in the Ministry of Health wrote to the Chief Secretaries of States that 'it might not be much of exaggeration to say that *1976 was the years of family planning in India* [italics mine].'[176] Further, the December 1976 issue of *Centre Calling,* a Ministry of Health publication, noted- 'Never in the history of the family planning programme have the States achieved the national sterilisation targets manifold. It ranges from 400 per cent

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[173] Cited in Rao, *From Population Control to Reproductive Health : Malthusian Arithmetic.*, p. 47. To me it seems that then humble Minister mistook this address of Mrs. Gandhi as a dictation for the population policy statement thus ushering the era of compulsory sterilisations.

[174] Ibid., pp. 46-47.

[175] GOI, "Report of the Shah Commission of Enquiry," (New Delhi: Ministry of Home Affairs, Government of India (GOI), vol. 3, 1978). Cited in Rao, *From Population Control to Reproductive Health : Malthusian Arithmetic.*, p. 48.

[176] GOI, "Report of the Shah Commission of Enquiry.", p. 20. Selected citation from Rao, *From Population Control to Reproductive Health : Malthusian Arithmetic.*, p. 48; Bose, *From Population to People.*, p. 28.

to more than 100 per cent in an over whelming majority of the States and that too in eight months.'[177] On the question of target chasing and compulsory sterilisation, Desai aptly argued that 'while expanding its intervention into the family life, in the name of family planning, through compulsory sterilisation campaigns, it has never bothered to ensure minimum prerequisites for family to survive or perform even its basic functions, including family planning.'[178] Moreover, these compulsory sterilisation campaign during the emergency resulted into a combination of coercion, cruelty, corruption and cooked figures, which Bose termed as 'Sanjay Effect' and also noted, though we have estimated that about 70 lakh persons were victims of Sanjay Effect during the emergency, the spread effect (through communication and rumours) must have been substantial, which can be termed as 'Sanjay Multiplier'[179]. However, what merits conclusion is that the move backfired and the family planning programme received a serious setback, from which it recovered only after about five years[180] and in the election of 1977, the Congress Party was swept out of power largely due to what came to be described as the 'excesses' committed in the name of family planning.[181]

The new Government after the emergency came with new policy statement (April 28, 1977) which noted:

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[177] Cassen, *India: Population, Economy, Society.*, p. 120.

[178] Desai, *Urban Family Planning in India.*, p. 48.

[179] Bose, *From Population to People.*, p. 52, 55.

[180] Visaria and Visaria, "India's Population.", p. 68.

[181] R.G. Davison, "Political Will and Family Planning: The Implication of India's Emergency Experience," *Population and Development Review* 5, no. 1 (1979).

> The President in his address to Parliament on March 28, 1977, stated that "family planning will be pursued vigorously as a wholly voluntary programme and as an integral part of a comprehensive policy covering education, health, maternity and child care, family welfare, women's rights and nutrition." .....Government is totally committed to the Family Welfare Programme and will spare no efforts to motivate the people to accept it voluntarily in their own interest and in the interest of their children as well as in the larger interest of the nation. *The family planning has, however, to be lifted from its old and narrow concept and given its proper place in the overall philosophy of welfare.* It must be part of the total concept of positive health. .....The change in the name of the programme *from family planning to family welfare* is a reflection of the Governments anxiety to promote, through it, the total welfare of the family and the community. It is our intension to take the programme forward in the real sense as an investment in man. .....Compulsion in the area of family welfare must be ruled out for all times to come. Our approach is educational and wholly voluntary.....The government the attaches highest importance to the dignity of the citizen and to his right to determine the size of his family.[182]

Even the Janata Government, according to Desai, 'intensified the campaign of family planning programme increasingly creating a climate, if not of an open compulsion, of a subtle indirect one for justifying the need of using pressure (of various types and intensities) as a method of realising the target. Special statement by Prime Minister Morarji Desai, series of meetings by Ministers of States, a new debate launched by intellectuals and scholars through seminars,

[182] Excerpts from Family Welfare Programme- A Statement of Policy: April 28, 1977, issued by Shri Raj Narain, Union Minister of Health and Family Welfare, GOI. See Bose, *From Population to People.*, pp. 545-550 (appendix VI)

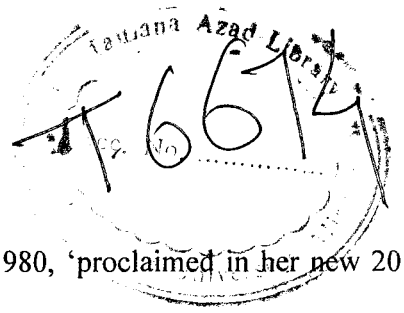
conferences, T.V. and other media, and climaxing into even Jayprakash Narayan being especially interviewed to secure his blessings and approval to intensify the programme of family planning by Government as a great priority for accelerating the tempo of economic and social development clearly highlight, how the family planning movement is being boosted as one of the top priorities by the Janata Government.'[183] Bose[184] further adds salt to it and observed that the Janata Government which came to the helm in 1977 *changed the nomenclature of family planning to family welfare but did precious little by way of introducing the welfare content* and expanding the family planning programme either in qualitative or quantitative terms [italics mine]. Further the Working Group on Population Policy (appointed by Planning Commission) in 1980 asserted 'population policy and general development strategy are the two sides of the same coin' and recommended that 'since women are the best votaries of the programme, the programme for the immediate future be increasingly centred around woman.'[185] The programme, Rao noted, 'henceforth came to be centred on women, since it was now abundantly clear that a programme focused on sterilising men was politically costly. In India's culture of course, women were expected to silently contribute to their family's welfare. It was on this fact and not on the need to

[183] Desai, *Urban Family Planning in India.*, pp. 128-129.

[184] Bose, "The Family Welfare Programme in India: Changing Paradigm.", p. 3. Elsewhere he noted, like renaming third class as second class in the Indian railways, we have also renamed family planning as family welfare planning. See Bose, *From Population to People.*, p. 34.

[185] GOI, "Report of the Working Group on Population Policy," (New Delhi: Planning Commission, Government of India (GOI), 1980)., p. 1, 36.

the increase the rights of women- that the programme now hinged itself, exploiting the weak and the defenceless.'[186]



Sixth Five-Year Plan (1980-85)

Mrs. Gandhi, on coming back to power in 1980, 'proclaimed in her new 20 Point Programme that family planning was to be promoted on a voluntary basis as a *people's movement* (Item 13). She also made a sincere effort to fill the family welfare basket with nutrition and maternal and child health programmes.'[187] Thus, noting the 'reverses' suffered by the programme, the Sixth Five Year Plan document, set out 'to arrest the trend'. The Plan observed, 'it is almost axiomatic that economic development can in the long run bring about a fall in fertility rates. However, developing counties with large populations cannot afford to wait for development to bring about a change in the attitude of couples to limit the size of their families as the process of development, itself is stifled by population growth. Limiting the growth of population is therefore one of the main objectives of the Sixth Plan.'[188] The Plan adopted 'long term demographic goal of reducing the net reproduction rate to one by 1996 for the country as a whole, and by 2001 in all the states' and the strategy adopted emphasized 'an integrated approach to the problems of public health and proper coordination of activities of different departments having a bearing on family planning such as maternal and child

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[186] Rao, *From Population Control to Reproductive Health : Malthusian Arithmetic.*, pp. 51-52.

[187] Bose, "The Family Welfare Programme in India: Changing Paradigm.", p. 3. Also see Bose, *From Population to People.*, p. xiv.

[188] GOI, "Sixth Five Year Plan," (New Delhi: Planning Commission, Government of India (GOI), 1980)., p. 375. Cited from Rao, *From Population Control to Reproductive Health : Malthusian Arithmetic.*, p. 53.

care' and that 'the family planning programme has to be made part of the national effort for providing a better life to the people.'[189] The Plan also acknowledged that 'high morbidity and mortality rates were responsible for the desire for more children.'[190] The outlay on family planning was again increased and amounted to Rs. 10.1 billion while health obtained Rs. 18.2 billion out of a total Plan outlay of Rs. 975.5 billion, representing 1.03 and 1.80 per cent of the total outlay respectively.[191] During the Plan period first post-independence National Health Policy was launched (in 1983) which noting the advances in health since independence, observed that- 'demographic and health picture still constitutes a cause for serious and urgent concerns. The high rate of population growth continues to have an adverse effect on the health of our people and quality of their lives' and while committing itself to the goal of Health for All by 2000 through the Primary Health Care system, the policy went on to argue that 'irrespective of changes, no matter how fundamental, that may be brought about in the overall approach to health care and the restructuring of the health care services, not much headway is likely to be achieved in improving the health status of the people unless success is achieved in securing the small family norm and moving towards the goal of population stabilisation.'[192] Thus, Rao laments, 'the cart of population control was placed before the horse of health care for

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[189] Cited in Rao, *From Population Control to Reproductive Health : Malthusian Arithmetic.*, p. 53.

[190] Ibid., p. 53.

[191] Ibid., p. 54.

[192] GOI, "National Health Policy, 1983," (New Delhi: Ministry of Health and Family Planning, GOI Press, 1983)., p. 2, 4. Cited in Rao, *From Population Control to Reproductive Health : Malthusian Arithmetic.*, pp. 54-55.

the people.'[193] In terms of operational strategy, what resulted was a *focus on female sterilisation*, often in camps. At the same time the availability of the laparascope made it possible to carry out sterilisations in record time, in operations described as something like a war and also that this same militarist fervour led, during this period, to the launch of trials with more lethal weapons: injectables (Net En and Depo), implants (Norplant), and indeed a vaccine.[194] The Plan period also witnessed youth Prime Minister, Mr. Rajiv Gandhi, coming to power (on account of Mrs Gandhi's sad demise) with a visionary model of development and accordingly, he revised the 20 point programme, the Item 9 of which proposes to 'bring about voluntary acceptance of the two child norm; promote responsible parenthood; reduce infant mortality; and expand maternity and child care facilities.'[195]

Seventh Five-Year Plan (1985-90)

In view of the actual performance in the Sixth Plan period, the goal of reaching a net reproducing rate of one was pushed forward from 2006 to 2011. The Seventh Plan set forth the following targets to be reached by 1990: 'an effective couple protection rate (CPR) of 42 per cent; a crude birth rate (CBR) of 29.1; a crude death rate (CDR) of 10.4; an infant mortality rate of 90 per 1000 live births; universal immunization of children, and antenatal care of 75 per cent of all pregnant women.....*The Plan emphasized the need to pay*

[193] Rao, *From Population Control to Reproductive Health : Malthusian Arithmetic.*, p. 55.

[194] Ibid., pp. 56-57.

[195] Bose, *From Population to People.*, p. 238 (Appendix II).

greater attention to MCH activities to enhance child survival [italics mine].'[196] Rao noted in this Plan the allocation to family planning was again increased, to be almost on per with that of health, a case of the tail wagging the dog. Family planning and health obtained an outlay of Rs. 32.56 billion and Rs. 33.92 billion respectively out of a total outlay of Rs. 1800 billion, representing 1.80 and 1.88 per cent of the budget respectively.[197] The plan period also witnessed the enunciation of another population policy. The National Population Policy (1986) which asserted that family planning 'is one of the essential components of the national strategy for growth which places equal emphasis on accelerated development and recognises the fact that the process of development is apt to be lopsided unless social-economic imbalances among the people, including the imbalances in the health services, are speedily removed. It looks at birth control not as an end in itself but as vital means to the attainment of 'Health for All' in the shortest possible time.'[198] The policy statement reiterates the Indian Government commitment to promote a voluntary, two-child norm. To this end, the policy committed itself to bring down morbidity and mortality rates, in particular early childhood mortality, through strengthened health services, enforcement of the law relating to age at

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[196] GOI, "Seventh Five Year Plan," (New Delhi: Planning Commission, Government of India (GOI), 1985). Cited from Rao, *From Population Control to Reproductive Health : Malthusian Arithmetic.*, p. 59.

[197] Rao, *From Population Control to Reproductive Health : Malthusian Arithmetic.*, pp. 59-60.

[198] GOI, "National Population Policy, 1986," (New Delhi: Ministry of Health and Family Planning, GOI Press, 1986)., p. 1. Cited in Rao, *From Population Control to Reproductive Health : Malthusian Arithmetic.*, p. 60.

marriage, health and population education, educational and employment facilities for women and so on.[199]

Eighth Five-Year Plan (1992-97)

The Eight Five Year Plan noted, 'containing population growth has been accepted by the Government as one of the six most important objectives of the Eight Plan with the aim of reducing the birth rate from 29.9 per thousand in 1990 to 26 per thousand in 1997. The IMR will be brought down from 80 per thousand live births in 1990 to 70 by 1997. To give a major thrust in this priority area, which constitutes the pivotal point for the success of all developmental efforts, a National Population Policy needs to enunciated and adopted by the Parliament.'[200] Rao noted in a welcome departure, for the first time, no centrally fixed targets were specified. This was not, of course, to mean that targets did not exist.[201] In this Plan, the operational strategy was spelt as area-specific, micro planning, linking population control with the programmes of female literacy, women's empowerment, social security, access to health services and mother and child care.[202] Health obtained an outlay of Rs. 75.82 billion while the allocation for family planning was Rs. 65 billion, representing 1.75 and 1.5 per cent of the total outlay respectively. The health outlay and family planning outlay thus declined from the allocations of

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[199] Rao, *From Population Control to Reproductive Health : Malthusian Arithmetic.*, p. 60.

[200] GOI, "Eight Five Year Plan," (New Delhi: Planning Commission, Government of India (GOI), 1992)., p. 334. cited in Rao, *From Population Control to Reproductive Health : Malthusian Arithmetic.*, p. 65.

[201] Rao, *From Population Control to Reproductive Health : Malthusian Arithmetic.*, p. 65.

[202] GOI, "Eight Five Year Plan.", p. 338. Cited in Rao, *From Population Control to Reproductive Health : Malthusian Arithmetic.*, pp. 65-66.

1.88 and 1.81 per cent respectively of the total outlay of the Seventh Plan.[203] Most significant event in the history of health and family welfare, world over, was the International Conference on Population and Development (ICPD) at Cairo, Egypt in 1994 and the commitment made to RCH (Reproductive and Child Health) approach by all participating nations, including India. Rao noted 'one positive outcome of the Cairo conference was the removal, formally, of method-specific targets in April 1995 on an experimental basis from Kerala and Tamil Nadu and from 17 districts in other states. In April 1996, targets were removed from all over the country.'[204] Hereafter (April 1996), the Family Welfare Programme is being implemented on the basis of Community Needs Assessment Approach (CNAA).[205] Furthermore, 'the Government of India launched the Reproductive and Child Health (RCH) programme on 15.10.1997 for implementing during 9th Plan period by integrating and strengthening all the existing interventions under the Child Survival and Safe Motherhood (CSSM) interventions of fertility regulation and adding the component of Reproductive Tract Infection (RTI) and Sexually Transmitted Infections (STI). The concept of RCH is to provide need based, client centred, demand driven, high quality and integrated RCH services to the beneficiaries.'[206]

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[203] Rao, *From Population Control to Reproductive Health : Malthusian Arithmetic.*, p. 66.

[204] Ibid., p. 66.

[205] GOI., "National Family Welfare Programme.", p. 162.

[206] Ibid., p. 144.

Ninth Five-Year Plan (1997-2002)

The Reproductive and Child Health Programme, which was launched in 1997 (to being implemented in Ninth Plan), focuses on the principles of client satisfaction and utilizing the exiting health infrastructure to deliver high quality health services.[207] The Ninth Plan stated that 'reduction in the population growth rate has been recognised as one of the priority objectives during the Ninth Plan period' and that 'the current high population growth rate is due to- the large size of the population in the reproductive age group (estimated contribution 60 per cent); higher fertility due to unmet need for contraception (estimated contribution 20 per cent); high wanted fertility due to prevailing high IMR (estimated contribution about 20 per cent).'[208] The priorities in the Plan were to meet *the felt needs for contraception*, and to reduce the infant and maternal morbidity and mortality so that there was a reduction in the desired level of fertility. In terms of budget, family planning received an allocation of Rs. 151.20 billion, a huge increase from Eighth Plan outlay of Rs. 65 billion, and the outlay for health at Rs. 51.18 billion, was a significant decline from the outlay of Rs. 75.82 billion in the Eighth Plan period, and representing 0.6 per cent of the total outlay.[209] The Government of India further proved its Cairo commitment and launched two major policies towards the end of Ninth Plan- that is National Population Policy (NPP), 2000 and National Health Policy (NHP), 2002. With the adoption of the National Population Policy, population and development have begun to once again

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[207] Jejeebhoy et al., "Setting the Stage.", p. 13.

[208] GOI, "Ninth Five Year Plan," (New Delhi: Planning Commission, Government of India (GOI), 1997)., p. 206, 207. Cited in Rao, *From Population Control to Reproductive Health : Malthusian Arithmetic.*, p. 68.

[209] Rao, *From Population Control to Reproductive Health : Malthusian Arithmetic.*, p. 68.

occupy centre-stage in the nation's agenda for social development.'[210] The National Population Policy 'provides a policy framework for achieving the *twin objectives of population stabilisation and promoting reproductive health within the wider context of sustainable development.* The immediate objectives of the National Population Policy are to address the unmet needs for contraception and health system personnel, and to provide integrated service delivery for basic reproductive and child health care. *The National Population Policy affirms the Government's commitment to the provision of quality services, information and counselling and expanding contraceptive method options in order to enable people to make voluntary and informed choices* [italics mine].'[211] Further, NPP listed its objectives in three frames-the *immediate objective* of the NPP was to meet the unmet need for contraception and health infrastructure. The *medium-term objective* is to bring the total fertility rate to replacement levels by 2010 through inter-sectoral action, while the *long-term objective* is to achieve a stable population, consistent with sustainable development, by 2045.'[212] NPP also stressed the need for decentralized planning, the empowerment of women for population stabilisation, child health and survival, collaboration with the voluntary and NGO sector, and encouragement of research in contraceptive technology.[213] Bose made a lengthy statement on trajectory of the National Population Policy and noted:

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[210] GOI., "National Family Welfare Programme.", p. 141.

[211] Cited in Jejeebhoy et al., "Setting the Stage.", pp. 13-14.

[212] Cited in Rao, *From Population Control to Reproductive Health : Malthusian Arithmetic.*, p. 213.

[213] Ibid., p. 213.

> As a member of the Swaminathan Committee on Population Policy which prepared a draft population policy in 1994 (before the much glamorised ICPD Cairo conference was held), I recall that we had suggested linking population to basic needs and 100 per cent fulfilment of the Minimum Needs Programme. The very first item in our list of national socio-economic goals for the year 2010 was implementation in totality of the Minimum Needs Programme.....Unfortunately this was cut out in the National Population Policy (2000) which put the first national socio-demographic goals for 2010 as follows- "Address the unmet needs for basic reproductive and child health services, supplies, and infrastructure." Glory to our population commission, India's decimal point demography and agents of market demography.[214]

In pursuance of the objectives of the NPP, the National Commission on Population (NCP) was constituted in May 2000 under the chairmanship of hon'ble Prime Minister to promote inter-sector co-ordination across agencies of the Central and State Governments, to involve the civil society and the private sector in planning and implementation and to explore the possibilities of international co-operation in support of the goals set out in the National Population Policy, 2000.[215] The National Health Policy aptly specified the common ground between NHP and NPP and noted- 'efforts made over the

[214] Bose, *Beyond Demography- Dialogue with People.*, pp. 203-204.

[215] GOI, "Annual Report 2005-06," (New Delhi: Ministry of Health and Family Planning, Government of India (www.mohfw.nic.in/Annual0506), 2006)., p. 27.

years for improving health standard have been partially neutralized by the rapid growth of the population. It is well recognised that population stabilization measures and general health initiatives, when effectively synchronized, synergistically maximize the socio-economic well-being of the people.....The synchronized implication of these two policies- National Population Policy, 2000 and National Health Policy, 2002- will be the very cornerstone of any national structural plan to improve the health standards in the country.'[216]

Tenth Five-Year Plan (2002-2007)

Tenth Plan[217] outlines efforts in three broad areas: 'a) meeting the unmet need for contraception; b) reducing infant and maternal mortality; and c) enabling families to achieve their reproductive goals. The targets included reduction in the decadal growth rate of population from 21.3 per cent in the period 1991-2001 to 16.2 per cent during the period 2001-2011. Efforts have been targeted toward addressing the unmet need for maternal and child health and contraception, particularly in states where mortality and child health and contraception have been lagging.' In India's policy planning, another landmark during the new millennium is the launch of National Rural Health Mission (NRHM) initially for the period 2005-2012. Its preamble notes 'Government of India has resolved to launch the National Rural Health Mission to carry out necessary architectural correction in the basic health care delivery system. The mission adopts a synergistic approach by relating health

[216] GOI, "National Health Policy," (New Delhi: Ministry of Health and Family Welfare, Government of India (GOI), 2002)., p. 16.

[217] Cited in Jejeebhoy et al., "Setting the Stage.", p. 16.

to determinants of good health viz. segment of nutrition, sanitation, hygiene in safe drinking water.'[218] The National Rural Health Mission (2005 -2012) 'seeks to provide effective healthcare to rural population throughout the country with special focus on 18 states, which have weak public health indicators and or weak infrastructure' and 'sets the target of reducing IMR to 30 and MMR to 100 and TFR to 2.1.'[219] Very recently, Government of India has introduced a Family Planning Insurance Scheme for acceptors of sterilisation and indemnity cover for doctors performing sterilisation procedures in both Government and accredited private/NGO/Corporate health facilities. The Insurance Scheme will be operated by the Oriental Insurance Company Ltd. (OICL). The Insurance Scheme provides (compensation) as the following: death due to sterilisation in hospital (Rs. 1, 00,000); deaths due to sterilisation within 30 days of discharge from hospital (Rs. 30,000); failure of sterilisation (including first insurance of conception after sterilisation) Rs. 20,000; medical complication occurring within 60 days of sterilisation operation (Rs. 20,000) (to be reimbursed on basis of actual expenditure incurred, not exceeding Rs. 20,000).[220]

[218] GOI, "National Rural Health Mission (2005-2012)," (New Delhi: Ministry of Health and Family Welfare, GOI Press, 2005)., p. preamble, 1.

[219] Ibid., p. 2, 15.

[220] GOI, "Annual Report 2005-06.", p. 30.

While the beginning which India made is impressive, the goal of population decline even after four decades (now five decades) remains a distant dream.[221] The population continues to grow at a faster rate than anticipated by India's planners and policy makers and every decennial Census sends shockwaves to them[222] and even made India's 'family planning programme suspect in the eyes of the common man.'[223] These poor results stem from an inadequate understanding of the Indian society.[224] Bose noted 'we have got into a rut of mechanically fulfilling family planning targets without paying adequate attention to the qualitative aspects of the family planning programme' and that '*the programme has emerged as massive monolithic programmes'* [italics mine].[225] The progressive increase in the importance attached to the policy of population control is well reflected in the successive plan allocations to the programme of family planning.[226] It is to note that under the Indian Constitution, health comes under the State List (Item 6 on List II reads as Public Health and Sanitation; and Hospitals and Dispensaries) while the social and economic planning including family planning come under the Concurrent

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[221] Hari Mohan Mathur and HCM Rajasthan State Institute of Public Administration., eds., *The Family Welfare Programme in India* (New Delhi: Vikas Pub. House in association with the HCM Rajasthan State Institute of Public Administration, 1995)., p. Preface, vi.

[222] Bose, "The Family Welfare Programme in India: Changing Paradigm.", p. 1.

[223] Bose, *From Population to People.*, p. 2.

[224] Mathur and HCM Rajasthan State Institute of Public Administration., eds., *The Family Welfare Programme in India.*, p. vi.

[225] Bose, "The Family Welfare Programme in India: Changing Paradigm.", p. 4. Also see Bose, *From Population to People.*, pp. 8, 11-12 and Bose, *From Population to People.*, p. 352.

[226] A series of scholars and analyst of repute have stressed and some even criticised the 'over-inflating' budget allocations to family planning in successive plans. See example Desai, "The Perspective of India's Population Policy.", p. 412., Mitra, *India's Population- Aspects of Quality and Control.*, p. 639, Bose, *From Population to People.*, and more recently Rao, *From Population Control to Reproductive Health : Malthusian Arithmetic.*

List (Item 20A of List III reads as Population Control and Family Planning). In effect, family planning is placed under the Union list as it has always been a cent per cent centrally sponsored programme. This created an anomaly[227]. The family planning programme has emerged 'as massive monolithic programme, centrally –financed, directed and monitored while the implementation of the programme is left to the States. Several States take interest in family planning only because the programme brings money from the central government. The Planning Commission is of the opinion that if the States are asked to share financial responsibilities, the family planning programme will collapse.'[228] Bose quotes D. Banerji who said 'health has been hijacked by family planning' and to this Bose aptly adds 'the plane crashed killing both health and family planning.'[229] Rao and Jain also support the same and argued that over the years, concern in family planning have contoured health sector developments.[230] Elsewhere, Rao also noted that 'the entire public health infrastructure, neglected, starved of funds; almost dysfunctional has been suborned for family planning. .....The entire primary health care (PHC) system, then has become besmirched with population control concerns.'[231] Ashish Bose[232] also found 'divergence within the Plans in the basic philosophy of family planning. Whereas the formulation of the plans was in term of the family planning as an integral part of the development planning,

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[227] On this anomaly Bose submitted suggestions to Sarkaria Committee on Centre-State Realtions on January 15, 1975. See Bose, *From Population to People.*, p. 357.

[228] Bose, *From Population to People.*, pp. 11-12.

[229] Bose, *Beyond Demography- Dialogue with People.*, p. 207.

[230] Mohan Rao and Devaki Jain, "National Population Policy 2000: Re-Examining Critical Issues," *Economic and Political Weekly* XXXVI, no. 16 (2001)., p. 1299.

[231] Rao, *From Population Control to Reproductive Health : Malthusian Arithmetic.*, p. 15.

[232] Ashish Bose, "Planning for Family Planning," *Yojna* (special number) (1966). Cited in Desai, "The Perspective of India's Population Policy.", p. 424.

the formulation of the programme has been in terms of family planning as an integral part of health planning. This divergence had far reaching implications for the actual implementation of the family planning programme'. He further contests, '*by hitching the family planning wagon to the passenger train of public health and not to the express train of development*[233], *the Plan blundered.*' It is rightly observed that the 'family planning is easier advocated than accomplished.'[234] Davis even said 'family planning is a euphemism for contraception.'[235] Davis aptly commented on the underlying assumption of family planning programme (and the probably reason for failure) that 'family planning can solve the problem of population growth seems to be taken as self evident.'[236] Bose noted what is disturbing is that the totality of the health situation has worsened in spite of the fall in mortality rates and a rise in the expectation of life.[237] Further, the above analysis clearly shows that there appeared no consistency in family planning programmes rather from Plan to Plan perspectives and strategies kept on changing whether it may be issue of relationship between socio-economic and demographic changes, or it may be adoption of new family planning and reproductive technologies. However, to add weight to this argument, let's quote from Rao as his authority is less likely to be challenged than mine. Rao noted, 'in past when family planning programme utilizing a particular approach ran aground- as it inevitably did -

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[233] A decade later Bose and other further argued to restore the problem of population more squarely into the focus of the problem of development. See Bose et al., eds., *Population in India's Development - 1947-2000.*, p. vi.

[234] S.Chandrasekhar, *Hungry People and Empty Minds.*, p. 15.

[235] Davis, "Population Policy: Will Current Programs Succeed?.", p. 370.

[236] Ibid., p. 371.

[237] Ashish Bose, "Health for All by 2000: Broken Promises," *Economic and Political Weekly* XXXVI, no. 11 (2001)., p. 905.

the way out of the impasse was adopting a new approach built around a new technology. Thus with the failure of the *clinic approach* began *extension education approach.* But before this would really get off the ground, the *intrauterine contraceptive device* (IUCD) was hailed as the magic bullet to defuse the population bomb- to use militarist metaphor! The IUCD approach having failed, it was *vasectomies*, and that being politically costly, attention turned to *female sterilisation.* Yet even this seemed to lead down a blind alley [italics mine].'[238] Santha[239] has noted that though the family planning programme has experienced growth and expansion over the past half century, pregnancies continue to be unplanned and the current need for contraception remains substantially high. According to Jejeebhoy and Santha[240] a vast shift in orientation is evident in a number of policy documents and programmes. The National Population Policy, the Tenth Five Year Plan and the Reproductive and Child Health programme for example all stand testimony to the fact that there is a commitment at the highest level to the broader health agenda. Unfortunately, there has been a huge schism between the articulation of and commitment to the new paradigm at the highest levels and its operationalisation at the community and grassroots level. It is rightly observed that family planning efforts coupled with the socio-economic improvements seem to hold a greater promise for the decline in fertility in India.[241] Bose further added, 'India's family planning programme will certainly succeed if

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[238] Rao, *From Population Control to Reproductive Health : Malthusian Arithmetic.*, pp. 16-17.

[239] K.G. Santha, "Contraceptive Use Dynamics," in *Looking Back, Looking Forward : A Profile of Sexual and Reproductive Health in India*, ed. Shireen J. Jejeebhoy (Jaipur and New Delhi: Rawat publication and Population Council, 2004)., p. 41.

[240] Shireen J. Jejeebhoy and K.G. Santha, "Loooking Back, Looking Forward," in *Looking Back, Looking Forward : A Profile of Sexual and Reproductive Health in India*, ed. Shireen J. Jejeebhoy (Jaipur and New Delhi: Rawat Publication and Population Council, 2004)., p. 183.

[241] Pathak and Singh, "Fertility Transition in India.", p. 180.

we inject in the programme, the health and education consciousness of Kerala, the people's involvement as in Gujarat, the contribution of the organised sector as in Maharastra and the rural prosperity and dynamism of Punjab. We do not have to look to Singapore or Taiwan or South Korea for success stories.'[242] Mohan Rao after looking over the Malthusian and neo-Malthusian red herrings, and undertaking an exhaustive review of Five Year Plans, concluded, 'the problems faced by the Indian family-planning programme are thus not solely technical, administrative, or strategical. The neo-Malthusian understanding of the population issue lies at the heart of the programme's failure to understand the issue differently.'[243]

Truly, this more than half century chequered history of India's family planning programme and unabated population growth even today, left us to have only pity with government. But it raises questions as why family planning programmes have not penetrated into the houses and hearths of masses? Why there is mass apathy to family planning programmes or more specifically, the contraceptives? Who are the adopters of family planning? What are their characteristics? Therefore without denying the significance of variety of social sciences researches hitherto done, here is a modest attempt to explore the determinants in the adoption of family planning/ family welfare programmes.

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[242] Bose, *From Population to People.*, p. 69.

[243] Rao, *From Population Control to Reproductive Health : Malthusian Arithmetic.*, p. 117.

1.4 Social Work Education, Research and Family Planning

Family planning rests heavily on multi-disciplinary approaches and inputs, and 'is no one's sole domain'.[244] Similarly, Pathak reviewing objectives of family planning in the country (India) and elsewhere noted that we can group them under four headings- demographic-economic objectives, welfare of the families and the children, health of the mothers and infants, and lastly, improvement of the women's status; and thereafter, argued that family planning programmes do not exclusively belong to any one profession or discipline and that it is a multi-disciplinary field.[245] More interestingly, ever since the very inception first global official family planning programme (in India), 'it was felt that social workers could play a significant role in its success.'[246] Cogently clustering the history of social work and family planning in India, Indira Patel laments:

> However, neither the Government nor the profession recognized it (family planning) as a potential field of social work practice and consequently social work profession remained outside the programme even till 1970. There has been a dynamic change in the attitude of social work educators

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[244] M.S. Gore, "Key Note Address," in *Social Work Education and Family Planning*, ed. ASSWI (Bangalore: Proceedings of the Workshop, May 5-10, 1972, Association of Schools of Social Work in India, 1972)., p. vii.

[245] S.H. Pathak, "Strategy and Need for Multi-Professional Approach and Contribution of Social Work to Achieve Objectives of Family Planning," in *Social Work Education and Family Planning*, ed. ASSWI (Bangalore: Proceedings of the Workshop, May 5-10, 1972, Association of Schools of Social Work in India, 1972)., pp. 72-74.

[246] Indira Patel, "Introduction," in *Social Work Education and Family Planning*, ed. ASSWI (Bangalore: Proceedings of the Workshop, May 5-10, 1972, Association of Schools of Social Work in India, 1972)., p. ix. As early as 1952, than leading Indian demographer S. Chandrasekhar pondered over the social work domain and presented a paper entitled 'Demographic aspect of Social Work' at the Indian Conference of Social Work at Calcutta.

> towards the role of social work profession. From its mere ameliorative approach it has accepted the challenge of social change and the need of mobilisation of its knowledge and skills to the tasks of planned social development. It has come to recognize that family planning programme is one such programme of planned national change and development and consequently social work educators have cared to transcend the frontiers of their clinics and of the small group settings to visualize their role in this challenge of national attitude and behaviour modification [addition and italics mine].[247]

During 1970s[248] there seemed to be a spurt of social work initiatives in family planning. For example, the International Conference on Social Work Education organised a workshop on the theme 'Family Planning and Population Dynamics' at Manila in 1970 and focussed the attention of social work educators all over the world in general, and in the developing countries in particular, to their role in the national family planning programme.[249] In the same stream recognising the needs for national consideration of the challenge, the Association of Schools of Social Work in India (ASSWI) organised a five days workshop on the theme *Social Work Education and Family Planning* to help determine the role of schools of social work in promoting social change and development in India through focus on family planning programme.[250] In his key note address to the same ASSWI workshop, Gore noted, 'we have, however, gradually come to realise, that in spite of campaigns of mass

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[247] Ibid., pp. ix-x.

[248] Basically, the decades 1960s-1970s are considered as the golden period of demographic studies in India, and even in third world countries, so it is no accident that there was an upsurge of initiatives to explore the role of Social work profession in family planning and the typology of relationship and need and necessity of social work research in this area.

[249] Cited in Patel, "Introduction.", p. x.

[250] Ibid., p. x.

vasectomy and free distribution of contraceptives, the results achieved are often marginal; something is still left undone, and there is something more to family planning than the mere availability of contraceptives at low cost. *The user has to use the available method and this depends upon psycho-social factors. Family planning in turns has social consequences for the practising individuals and this is only being realised gradually* [italics mine].'[251] Lydia Rappaport in her attempt to quantify the social worker's roles and functions in family planning, outlined the scope of family planning and stated:

> One key concept is the regulation of fertility by preventing unwanted pregnancies by spacing the number of children desired. This gives families mastery over their reproductive functions and enlarge their capacity for choice and self direction in individual and private family goals.....Family planning is also embedded in the health matrix and seeks to make an impact on foetal wastage, prematurity, maternal mortality and morbidity and child health. It is also rooted in concepts of social and psychological well being in its emphasis on strengthening the quality and stability of family life. Thus it becomes a measure for positive mental health. Family planning objectives include not only conception control but also help with problems of infertility, although this dimension is unplugged in actual practice. Thus family planning deals with the promotion, postponement and prevention of conception.[252]

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[251] Gore, "Key Note Address.", p. vi.

[252] Lydia Rappaport, "Education and Training of Social Workers for Roles and Functions in Family Planning," *Journal of Education for Social Work* 6, no. 2 (1970). Cited in Kamala Gopal Rao, "Health and Educational Approach to Family Planning-a Review of Studies and Implications for Social Worker's Education," in *Social Work Education and Family Planning*, ed. ASSWI (Bangalore: Proceedings of the Workshop, May 5-10, 1972, Association of Schools of Social Work in India, 1972)., pp. 14-15.

Rappaport assertion is taken forward by Florence Hasel Korn who highlighted '*the compatibility of the value base of family planning and social work in regard to the right to opportunity for self-realization and the right of self-determination regarding freedom of choice in decisions affecting one's own fate. Even at the level of more instrumental values in regard to enhancing, strengthening, and preserving of family life which are the chief concerns of social work, there is almost an emphatic convergence of interest between social work and family planning* [italics mine].'[253] In 1972, M.S. Gore observed that the interest of social workers in family planning flows from certain premises- 'family planning is a problem of critical importance to the country and to the world. Even with the relative plenty of food in the country today, the problem of population is still a pressing one. Unless a solution is found to the problem, it can spell disaster for all over development programmes. If the problem is of such a great importance, obviously social workers must make a contribution.'[254] Visaria looked from another angle and argued, 'it is possible that people like to avert the risk of being left without any children and their behaviour might therefore be governed by the least encouraging experience they observe. *If this presumption is valid, those who attempt to persuade the people to limit their family size have to make a very important distinction in their appeals, depending on the group to which they talk. The social workers who deal with the problem either on an individual or on a group basis would also do well to pay attention to this very important*

[253] Cited in Rao, "Health and Educational Approach to Family Planning-a Review of Studies and Implications for Social Worker's Education.", p. 32.

[254] Gore, "Key Note Address.", p. v.

phenomena.'[255] He further noted, 'the humane concern of social workers with the quality of life and their awareness of the conflicts inherent in the process of social change can reasonably be expected to help accelerate the social engineering programmes which aim at or depend on the goals and values of the people.'[256] Rao aptly argued, 'the existing gap in educational, motivational and behavioural change efforts and services in family planning can be filled up only when professions like social work contribute their knowledge and skills to improve programme.'[257] Noting that the association of the profession of social work with the programme of family planning is of recent origin, Nanavatty noted, 'social work is basically meant to enable individuals, groups and communities to improve their social situations, to adjust to the changing conditions, and to participate in the tasks of development. Its interest in family planning and population control is in basic conformity with its objectives..... The contribution of social work to family planning can be manifold. It may relate to direct services, to areas of motivation and communication, to supportive services, to the determination of policy, to programme formulation, and to evaluation and research.'[258] Later in 1988 Ashish Bose noted that the family planning programme must be de-bureaucratised and put in professional hands aided by dedicated social

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[255] Pravin Visaria, "Contributions from Demography for the Training of Social Workers," in *Social Work Education and Family Planning,* ed. ASSWI (Bangalore: Proceedings of the Workshop, May 5-10, 1972, Association of Schools of Social Work in India, 1972)., pp. 44-45.

[256] Ibid., p. 54.

[257] Rao, "Health and Educational Approach to Family Planning-a Review of Studies and Implications for Social Worker's Education.", p. 32.

[258] Meher C. Nanavatty, "Social Welfare Aspects of Family Planning," in *Social Work Education and Family Planning,* ed. ASSWI (Bangalore: Proceedings of the Workshop, May 5-10, 1972, Association of Schools of Social Work in India, 1972)., pp. 59-60.

workers, taking the maximum advantage of modern methods of communication.[259]

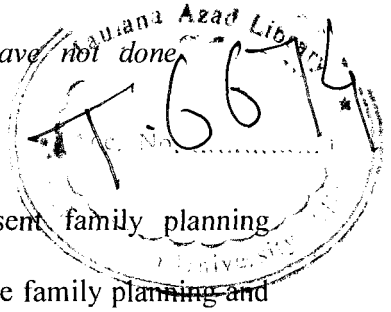
Thus, the relationship of social work and family planning merits endurance for a plethora of reasons. The social work profession's basic objectives, core humanitarian values and client centred approaches on the one hand and family planning inertia among Indian masses on the other, all points to need, necessity, and significance of relationship between the two. Pathak convinced of the synchronised social work and family planning dyad, pondered over the researches in family planning and the space for social work research. He aptly puts together family planning and social work research as:

> The environmental aspect has been neglected in both family planning research studies and the implementation of programme. Though there has been an increase in the number of research studies on communication in the family planning field during 1960s, most of these studies have been focussed on the message, object and channels of communication. The different researches have tended "to look at the communication process from the sources point of view, rather than the receivers."[260] Social work as a profession has always recognised the importance of motivation in human behaviour, has given great attention to this aspect in practice and has emphasized the importance of looking at the problem from the client's point of view. *It is my contention that social workers in India are more suited to conduct studies on motivation in family planning by virtue of their orientation, background and*

[259] Bose, *From Population to People.*, p. 116.

[260] Everitt R. Rogers and F. Floyd Sheenaker, *Commmunication of Innovations- a Cross Cultural Approach* (New York: The Free Press, 1971)., pp. 78-79.

professional practice. It is true that they have not done research in this so far [*italics mine*].[261]



He further added that the main weakness of present family planning programme is in the latter area i.e. motivation to practice family planning and effective follow-up in case of irregularity or complications. It is in this respect that social work can, make a very effective contribution.[262] Bhendre is of opinion that family planning studies can broadly be categorised under the following heads: KAP (Knowledge, Attitude and Practice) studies, studies of acceptors of contraception, and communication studies[263] and in her background paper on social work research she even suggested that social worker has legitimate claim to be involved in research in all the three areas.[264] Gindy has raised the question why those fields of research should be of particular interest to social workers when those have already engaged the attention of sociologists, anthropologists, psychologists, and other social and behavioural scientists. The answer lies in the social worker's unique knowledge of the individual, his behaviour, feelings, values, attitudes, anxieties and family relationship all of which are major factors underlying any social work research carried out in the field of family planning.[265]

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[261] Pathak, "Strategy and Need for Multi-Professional Approach and Contribution of Social Work to Achieve Objectives of Family Planning.", pp. 75-76.

[262] Ibid., p. 79.

[263] Asha Bhendra, "Family Planning Research and Social Work Education," in *Social Work Education and Family Planning*, ed. ASSWI (Bangalore: Proceedings of the Workshop, May 5-10, 1972, Association of Schools of Social Work in India, 1972)., p. 118.

[264] Ibid., p. 140.

[265] Aida Gindy, "Social Work Roles and Opportunities for Service," in *Population Dynamics and Family Planning: A New Responsibility for Social Work Education*, ed. Katherine A. Kendall (New York: Council of Social Work Education, 1971). Cited in Bhendra, "Family Planning Research and Social Work Education.", p. 128.

In view of *supra*, the relationship of social work and family planning is well established and grounded. However, in India it was a hot topic decades ago, does it still has enough warmth to be picked up for the social work research exploring the personal and familial characteristics in the adoption of family welfare programmes! Here, it is suffice to mention that in India of new millennium-high unmet need (for contraception) exists, contraceptive technology is available, post-Cairo new population policy clarion for informed choices, client centred target free approach but population growth is unabated and more pressing than of the time when there was spurt of studies and social work was no exception. Thus, the gravity of problem on one hand and paradigm shift with client centred approach on other, together provides not only much space to social work research but makes it inevitable for a profession that is heavily rooted in client centred humanitarian philosophy. Further, given the cultural diversity of country, as social workers we must, to borrow from Jeanne C. Marsh, 'give much consideration to effective social work practice in a multicultural society.'[266] The consequent sub-chapters (on literature review and justification of study) and the next chapter (on research methodology) attempt to elaborate the need, necessity and rationale of undertaking present research, and the modalities of undertaking the same.

[266] Jeanne C. Marsh, "Social Work in a Multicultural Society," *Social Work* 49, no. 1 (2004)., p. 5.

1.5 Literature Review

Bose[267] review of progress in demographic research in 1970 not only observed increasing emphasis on fertility and family planning surveys in Indian demography (which at present is not our cause of concern) but did show the persistence of population studies in pre-independent (as already discussed) and in post independent India. His article mentioned Tara Patankar[268] whose bibliography of fertility studies listed 200 such surveys while another bibliography prepared by Kapil and Saksena listed 245 studies on sterilisation and KAP (knowledge, attitude and practice of family planning) in India conducted since 1950. K.G. Rao[269] reviewed 550 such KAP studies on fertility, family planning and contraceptive practice since the launch of national family planning programme but she seemed not very amused of the scope of these studies. As stated earlier one has to be very parsimonious (others may differ) with this literature of oceanic depth on the issue of population, fertility and family planning. One may ask if such is the gravity of available literature why is the present research! Leaving the answer to be answered later on, in the forthcoming paragraphs an attempt is made to review the major much quoted studies across each decade to understand the nature of these studies and accordingly the need for the present one.

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[267] Bose, "Studies in Demography."

[268] Tara Patankar, *A Bibliography of Fertility Studies in India* (Bombay: Demographic Training and Research Centre (Mimeographed), 1969)., Krishna K. Kapil and Devendra N. Saksena, *A Bibliography of Sterilisation and Kap Studies in India* (Bombay: Demographic Training and Research Centre, 1968). Similar were other studies like K.G. Krishna Murthy, *Research in Family Planning in India* (Delhi: Sterling Publisher, 1968)., D.V.R. Murthy, *Studies in Family Planning in India* (New Delhi: Central Family Planning Institute, 1967). Cited in Bose, "Studies in Demography.", pp. 33-35.

[269] K.G. Rao, *Studies in Family Planning: India* (New Delhi: Abhinav, 1974).

The Mysore Population Study[270] (MPS) conducted in 1951-52, a joint venture of United Nations and Government of India provided valuable information on births, deaths, age at marriage and the motivational aspects of fertility regulation. The MPS collected data from about 10,000 households in rural and urban areas of the old Mysore State and was an experiment in the use of sample survey of households to measure the trends and characteristics of population and also to examine the inter-relationship between fertility behaviour and socio-economic development. A clear positive association between fertility and economic status in rural areas was observed. In the urban areas the lower non-manual groups and skilled manuals workers show slightly larger families than other occupational groups. The study found a curvilinear relationship, with fertility increasing with education and then declining with further education. In Bangalore city there was no appreciable difference in the fertility below the level of high school education, and in rural areas, the illiterate were less fertile than women who were literate or had attended the upper primary and middle schools. The lowest fertility was found only among women who had above high school and University education. More importantly, study found that the economic advantage of children to the parents either in the immediate future or in the old age was most important reason for having a large family. It was further noticed that the motive for having a large or small family size was mainly parent-oriented i.e. the motives were perceived advantages for parents and not for children. Some other reasons which are conducive for having more children were 'to avoid community criticism', 'to follow the community pattern', and 'to follow the

[270] U.N., "The Mysore Population Study," (New York: United Nations, 1961).

example of friend or relatives'. The findings of the study indicate the importance of understanding the whole social milieu of the respondents before analysing their fertility behaviour.

The early years of 1970s witnessed the famous Khanna study in Punjab by Wyron and Gordon[271], and its re-study by Mamdani[272]. The Khanna study, based on experimental design comprised three study areas, that is, one study population and two control populations in Ludhiana district of Punjab. The study population were to be served by a resident staff to make monthly household visits to acquaint each family in the sample with the advantages of family planning and to supplement the necessary material. One of the control areas was used to measure the influence of data collection while the other was used to obtain data on births and deaths. Participant observation was claimed to be the standard method of fieldwork in this phase of the study although it explored sexual and contraceptive practices. The definitive study lasted four years from 1956-60. For most of the first year, acceptance of contraceptive approximated the expected 25 per cent of all eligible couples. Towards the end of 1957, acceptance rates declined and never subsequently reached a figure that could have made a difference in the birth rates. However, both the authors observed that over population is a melody of society that produces wasted bodies, minds and spirits just as surely as other familiar scourges- leprosy, tuberculosis, cancer. These observations clearly smack of the authors master's voice, the funding organisations which included Rockefeller Foundation and

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[271] J. B. Wyon and John Everett Gordon, *The Khanna Study : Population Problems in the Rural Punjab* (Cambridge, Mass: Harvard University Press, 1971).

[272] Mahmood Mamdani, *The Myth of Population Control : Family, Caste, and Class in an Indian Village* (New York ; London: Monthly Review Press, 1972).

their neo-Malthusian *mantra.* Fortunately, Khanna villages were revisited by Mamdani to refute the high hearted claims of Khanna study *in verbatim.* Mamdani sought an alternative understanding of the population problem-by locating the problem in a context, by way of understanding the living and working conditions of the population, the role of technology in a given social context, the importance of the family labour, and the influence of all these factors in shaping the desired family size. He argued that given the material conditions of the population studied, there existed a necessity for family labour, which in turn determined family size. There was, therefore, rationality in the given socio-economic context for the peasant's desire for a large family. This desire then was not rooted in either ignorance or irrationality. Indeed, he concludes that by and large, for all section of the agrarian population, resorting to family planning would be 'to court economic disaster'. Thus, unlike 'super' rationality of Khanna study, Mamdani's plain logic proposes to see fertility in the prevailing socio-economic and demographic conditions. It may not be hyperbolic to say that large family size of the sampled population reflected nothing but the survival strategy of rural masses in an age of high mortality. Towards, the close of 1970s Khan[273] came up with *Family Planning among Muslims in India,* based on a sample of 330 Muslim couples randomly chosen from the Muslim dominated localities of Kanpur city. This micro-exploratory study (as author claimed) is discussed here for two reasons, one it was a brilliant attempt to correlate and single out determinants of fertility (demographic, socio-economic, family and psychological variables) and contraception adoption using sophisticated statistical tools and secondly, it has

[273] Khan, *Family Planning among Muslims in India.*

as its sample, a community, that is Muslims, who are much quoted as apathetic to family planning. Khan argued that total number of children dead, perceived child mortality and the sex preference of wife were negatively associated with contraception and also noted that looking at the set of regression equations for the total sample, it appears that the number of living children, husband-wife communication, husband-wife empathy and perceived burden of children are all equally important predictors of family planning acceptance. The study showed that just 50 per cent of the total sample had used contraception at one time or other and thus contradicts the general belief that Muslims does not accept family planning. However, the limitation with the study was that it became more quantitative (though author made liberal use of respondent 'typical' responses in their language) and therefore failed to highlight dynamic processes in the contraceptive adoption which move beyond the couple, around whom author's indexes (for example husband-wife empathy index) and regression results revolved.

In 1980 Desai[274] came up with brilliant sociological critique of family planning studies and fallacy of programme approach. He reviewed and quoted from major preceding pioneering works, (for example Agarwal[275], Mukherjee[276], Banerji[277], Kavoori[278], Dandekar[279], Mitra[280], and many

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[274] Desai, *Urban Family Planning in India.*

[275] S.N. Agarwala, *Some Problems of India's Population* (Bombay: Vora, 1966)., p. 157.

[276] Ramkrishna Mukherjee, *Family and Planning in India* (New Delhi: Orient Longsman, 1970)., p. 15

[277] D. Banerji, "Stategy for Family Planning in India- Retrospect and Prospect," (Mimeographed, 1972)., p.1.

[278] Kavoori, "Reconstruction of the System.", p.21.

[279] Kumudini Dandekar, "Fertility- Its Control and Future Prospects," in *Population in India's Development- 1947-2000*, ed. Ashish Bose, et al. (Delhi: Vikas, 1974)., pp. 340-341.

more)[281], who have highlighted the limitations of family planning programme and reasons for debacles in the successive Five Year Plans but did emphasize the importance of programme and the need to curb population growth[282]. Desai in the same fashion lambasted on government's much focus on 'population control', targets and strategies and finally made a very strong 'submission' for programme failure and argued that, 'unless the family planning programme examined in the context of socio-economic development that is taking place in India as a consequence of planning based on *capitalist mixed economy path*, the above mentioned shifts can never be understood. .....It is puzzling that our established scholarship, while pointing out some of the limitations of family planning movement have never systematically laid bare the *basic relationship between the path pursued for national development and the "population control" assumption adopted for the family planning movement* [italics mine].'[283] Thus, he blamed the very path of developmental planning for the family planning debacles[284] and

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[280] Mitra, *India's Population- Aspects of Quality and Control.*

[281] All these studies made cogent analysis of necessity of curb on population growth, common man rationality of having large families and wrong premises of family planning programme which *per se* is not bad. These scholars have also dwelled heavily on limitations of researches on family planning. Mitra's, for example, exhaustive account of limitations in researches undertaken also include the 'overlapping and repetitive nature of KAP studies undertaken since 1950-52.' Mukherjee lamented the lack of perceptual data to explain why people have not taken to family planning as a self generating process.

[282] For example Mukherjee observed 'the family planning to reduce couple-children ration appears to be needed on two main counts- 1. The population growth rate affects adversely the present rate of economic growth, as measured by, say, GNP per capita. *It thus does not lead to economic development.* 2. The rapid increase in population creates difficulties to produce adequate education, health facilities, social and cultural amenities, etc; in order to bring the people on par with those in the 'developed' countries. *It thus affects the course of 'social development'* [italics mine].' (p. 17).

[283] Desai, *Urban Family Planning in India.*, p. 146.

[284] More recently the Indian model of development is again questioned by Ravindra as being 'a major cause of its current economic conditions i.e. it seeks increased productivity rather than an equitable distribution of resources, and subsidies in public health and education for the poor. See T.K. Ravindra, "Women and the Politics of Population Development in India,"

towards the end of the book he became very critical (even pessimistic) and opined that 'India's approach brings to mind Barry Commoner's words in *The Closing Circle*: "war is a means of solving a social issue, not by social means but by a biological process, death." The same is true, I believe, of enforced population control.'[285] In this decade (1980s) a very large scale field study was carried out in five districts of Uttar Pradesh by Mishra and others[286] to understand the functioning of family planning programme and the reasons for the poor response it received. This study utilizes what is described as an open system framework to emphasize the interrelatedness of factors-economic, social, demographic and organisational- which govern family planning acceptance. The study covered a massive sample comprising 45 primary health centres (15 each in poor, average and well performing PHCs selected at random) and 3000 couples selected at random. The significant findings that emerged were that the mean household size and land ownership are positively related. The landless poor thus have the smallest household size. Infant and child mortality were extremely pervasive with the majority of families experiencing the death of at least one child; of those who had more than two live births, the majority had seen at least one child die. Possibly because of its pervasiveness, infant and child morality data is not presented in relation to income and landholding. Given the nature of agrarian economy, it is not surprising that a substantial proportion of the population felt that children

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Reproductive Health Matters 1 (1993)., p. 27; also see M. Vijayanunni, *Policies, Programmes and Population Change in India* (Delhi: B.R. Publishing Corp, 1995).

[285] Desai, *Urban Family Planning in India.*, pp. 193-194.

[286] B. D. Mishra et al., *Organisation for Change: A System Analysis of Family Planning in Rural India* (New Delhi: Radiant Publishers, 1982). On similar pattern were empirical studies in other states on India for example R. Anker and M. Anker, *Reproductive Behaviour in the Households of Rural Gujarat* (New Delhi: Concept, 1982).

played an important role in the household economics- although this data is not provided by income or landholding categories. The study concluded that socio-economic conditions act as a barrier to fertility reduction. On this Rao[287] noted the 'neo-Malthusian thinking turned on its head!' According to Rao, while the critical importance of socio-economic factors is glaring the authors themselves do not give this the attention it deserves. Thus, much of the data- education, age at marriage, desired family size and so on- is not presented in relation to landholding or income strata. The study does note that income, caste, education, and landholding are closely related. Towards the close of decade Bose[288] presented a very exhaustive account of family planning programme, its inherent fallacies and unavoidable promoters (donar agencies) in his two volumes *From population to people.* The title itself reflects the coercive family planning promotion during emergency and urgent need of people's participation[289]. Overall both volumes are an excellent critique- one dwells more on family planning programme, family planning

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[287] Rao, *From Population Control to Reproductive Health : Malthusian Arithmetic.*, pp. 141-142.

[288] Bose, *From Population to People.*, Similar are other critiques for example M. E. Khan and D. V. N. Sarma, *Socio-Economic Development and Population Control* (New Delhi: Manohar, 1988), Raina, *Population Policy.*, Khan and Sarma, *Socio-Economic Development and Population Control.*, Vinayak Mahadev Dandekar and J.S.S. Institute of Economic Research., *Population Front of India's Economic Development, Hukerikar Memorial Lecture ; 1987* (Dharwad: J.S.S. Institute of Economic Research, 1988)., A. Bose and P.B. Desai, eds., *Population Planning in India: Policy Issues and Research Priorities* (Delhi: B.R. Publishing Corp., 1989), India. Ministry of Health and Family Welfare. and Centre for Research Planning & Action (New Delhi India), *Population Management through Linking Family Planning with Socio-Economic Development Programmes : A Study Prepared for the Ministry of Health & Family Welfare (Department of Family Welfare)* (New Delhi: Centre for Research Planning & Action, 1989)., K. Mahadevan, ed., *Fertility Policies of Asian Countries* (New Delhi: Sage, 1989).

[289] A full fledge study was undertaken in two major states of India i.e. Madhya Pardesh and Gujarat to explore the possibility of people's participation in family planning. The study examined two models i.e. NGO model and Panchayati Raj model and find that peoples are much ready provide effective mobilisation and in the same NGOs were more successful. V.A. Pai Panandiker and Ajay K. Mehra, *People's Participation in Family Planning* (New Delhi: Uppal Publishing House (under the auspices of Centre for Policy Research), 1987).

inertia among masses and ways out of impasse while the second volume highlights unfruitful contribution of donor agencies, target centric bureaucracy and family planning initiatives in other countries, from where our policy makers frequently draw much inspiration, so Bose helps them out!

During the 1990s, one of the major qualitative and empirical work was the ethnographic study of fertility behaviour in Rajasthan by Patel[290], first published in 1994. The study attempted to understand fertility behaviour as an integral part of the village society and highlights the view that instead of measuring directly the impact of socio-economic factors on fertility, substantial insight are gained in exploring and analysing the specific institutional mechanism through which socio-economic factors operate. The findings reflected the socially prevalent prescriptions and proscriptions about- when to begin fertility career and when to end, and how many children (socially optimum number) and of what sex. The cosmology and even social onomastics reflect and reinforced fertility practices, as well as social management of pregnancy and childbirth. The study also documented the pervasive occurrence of infant and child deaths, with every woman in the study village having lost a child or more and noted that social norms of fertility and the repository of experiences of past and present fertility and mortality continue to influence people's behaviour in favour of high fertility. The study also appreciated indigenous fertility control measures (their effectiveness immaterial), and that the sterilisation is ridiculed in village society while modern temporary methods like condoms, pills and IUD are

[290] Patel, *Fertility Behaviour*.

unmanageable. However, it seems that Patel herself was overwhelmed by her attempt to have integrated view of fertility behaviour and overlooked the plights poor reproductive trajectory of women (though she noted and shared bitter pregnancy experiences of women and their clarion for 'injectables' to restrict fertility) and high unmet need for modern contraceptives as the traditional methods are of doubtful value. This study proved to a large extent that fertility behaviour is culturally determined rather than by socio-economic variables. However, like the macro socio-economic fertility studies this study reached the same end by its quest to find answer in micro cultural practices. After Patel's empirical study, came an edited volume *The Family Welfare Programme in India* by Hari Mohan Mathur[291], containing a good mix of critiques and empirical studies written by great and goods of time. Bose in his introductory chapter presented the changing paradigms of family welfare programme, while Talwar analysed the demographic transition in India and was supplemented by Pathak and Singh's chapter on fertility transition in India. Mathur himself brilliantly presented the social and cultural influences in fertility (moving close to Patel) and argued that there is a need to understand the people's beliefs and tradition to replace them with new ones. In 1996, Zodgekar[292] reviewed the basic philosophy of the family welfare programme and the role of development and population- influencing factors. Citing a number of studies showing programme contribution to, 'large scale awareness about family planning, contraceptives and available facilities'[293]; 'increasing

[291] Mathur and HCM Rajasthan State Institute of Public Administration., eds., *The Family Welfare Programme in India.*

[292] Zodgekar, "Family Welfare Programme and Population Stabilization Strategies in India."

[293] K. Mahadevan et al., "Development of Population Policies in India," in *Fertility Policies of Asian Countries*, ed. K. Mahadevan (New Delhi: Sage Publications, 1989).

number of sterilisation operations, IUD insertions and use of other contraceptive methods'[294]; 'decline in total fertility rate'[295]; Zodgekar raised the basic question 'whether the decline has been sufficiently large to merit applause for the efforts of family planning programme' and is of the view that 'birth rates and total fertility rates are still too high'. With regard to number of acceptors of family planning and their demographic characteristics he observed that, 'though the couple protection rate has increased from 10.4 per cent in 1971 to 44.1 per cent in 1991, most of this increase has been achieved through sterilisation. Also there has been some inconsistency between the couple protection rates and total fertility rates observed among various States. This raises a question concerning the accuracy of reporting the non- reversible methods used and the effectiveness with which they have been used. The demographic characteristics of the couples concerned also are not very conducive to a steep decline in fertility. The mean age of acceptors is above 31 years. These couples on average have at least 3.3 living children. This profile has hardly changed over the years. *This means that the programme has not been very successful in recruiting younger couples with lower parity* [italics mine].'[296] He further argued that 'it is essential to net "high-risk" couples in order to ensure the future success of the programme. Such couples naturally will be young and of lower parity. Because they would not be suitable candidates to recruit for sterilisation, attention certainly must be given to the

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[294] Raina, *The Population Challenge.*, p. 172.

[295] A.K. Jain and A.L. Adlakha, "Preliminary Estimates of Fertility Decline in India During the 1970s," *Population and Development Review* 8, no. 3 (1982), J.R. Rele, "Fertility Levels and Trends in India, 1951-81," *Population and Development Review* 13, no. 3 (1987), P. Visaria and L. Visaria, "Demographic Transition: Accelerating Fertility Decline in the 1980s," *Economic and Political Weekly*, no. December (1994).

[296] Zodgekar, "Family Welfare Programme and Population Stabilization Strategies in India.", pp. 5-6.

need for expanding the use of reversible methods.' On the issue of development and population influencing factors, Zodgekar made two very significant observations. One that '*unless significant progress is achieved in improving the status of women (i.e. education, health and labour force participation) in India, a further reduction in fertility is highly unlikely* [addition and italics mine].'[297] Secondly, on socio-economic conditions and family planning he was emphatic enough to conclude- '*there exists a threshold above which socio-economic development has to rise in order for the small family norm to prevail in society* [italics mine].'[298] The contribution of socio-economic conditions has also been validated by a good number of previous studies. Based on an analysis of 94 countries, Mauldin and Barelson[299] observed that, although programme efforts are important, programmes in countries with a better social setting are more successful. Bongaarts and others[300] have observed that *socio-economic development and family planning programmes "operate synergistically, with one reinforcing the other* [italics mine]." Even almost two decades before Bongaarts, Asok Mitra lamented that 'few have stressed that economic growth and population control are the two sides of the same coin.'[301] Kulkarni and Rani comparative study of fertility declines in China and India also lends support to the good mix of strong programme and moderate socio-economic conditions for better results.

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[297] Ibid., p. 21.

[298] Ibid., p. 22.

[299] W. Mauldin, Bernard Berelson, and Z. Sykes, "Conditions of Fertility Decline in Developing Countries, 1965-75," *Studies in Family Planning* 9, no. 5 (1978). Also see K.S. Srikantan, *The Family Planning Program in the Socioeconomic Context* (New York: Population Council, 1977).

[300] John Bongaarts, W. Parker Mauldin, and James F. Phillips, "The Demographic Impact of Family Planning Programs," *Studies in Family Planning* 21, no. 6 (1990)., p. 330.

[301] Mitra, "The Small Family Norm and Literacy.", pp. 290-291.

They concluded that 'the comparison of the fertility transitions achieved in China and some parts of India reveals that the decline in China has been more impressive than that of India and the decline has been achieved in a very short time. It is true that the socio-economic conditions in China were more favourable to a fertility decline than those, existing in India, but China's superiority was not overwhelming enough to attribute the difference in the declines to socio-economic factors. The Indian State of Kerala, which has a social setting comparable to that of China, has also experienced a large fertility decline but at a slower pace. Clearly, China's birth control campaign has played an important role in speeding up the fertility transition.'[302] There took place two very significant events in 1990s which gave a lot of raw material to hungry researchers that is *National Family Health Surveys* conducting during 1990-92[303] (NFHS-I) and 1998-99[304] (NFHS-II). These NFHS surveys offer some extremely interesting data on demographic differentials and some of their determinants. Chaudhury[305] on the eve of NFHS (1992-93) examined the interstate variations in fertility in relation to certain aspects of female status and the survival status of children. Female status is measured in terms of a woman's access to work outside the home and education. The survivorship status of children is determined by two indicators: (a) infant mortality rate and (b) child mortality rate. The bi-variate relationship is examined by using the technique of Parsonian correlation coefficients which

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[302] P.M. Kulkarni and S. Rani, "Recent Fertility Declines in China and India: A Comparative View," *Asia-Pacific Population Journal* 10, no. 4 (1995)., p. 70.

[303] IIPS, *National Family Health Survey (Mch and Family Planning) India, 1992-93* (Mumbai: International Institute for Population Sciences, 1995).

[304] International Institute for Population Sciences. and ORC Macro., *National Family Health Survey (Nfhs-2), 1998-99* (Mumbai: International Institute for Population Sciences, 2000).

[305] Rafiqul Huda Chaudhury, "Factors Affecting Variations in Fertility by States of India: A Preliminary Investigation," *Asia-Pacific Population Journal* 11, no. 2 (1996).

lend support to the hypothesized relationship between total fertility rate on the one hand and female status and child survival status on the other (i.e. higher the proportion of women in a State who are working outside the home for someone else, the lower is the fertility rate of that State; higher the proportion of women in a State who are formally educated, the lower is the fertility of that state and lastly, higher the infant/ child mortality levels of a State, the higher is the fertility of that State). Further, the results of multiple regression analysis confirm child mortality as the single most important variable affecting fertility, followed by the work status and education. Chaudhury very rightly argued that the 'female labour force participation will not result in lower fertility *per se* unless there is greater incompatibility between the roles of mother and woman.'[306] On the basis of this macro level analysis he also concluded that the 'higher the proportion of women in a state completing less than primary education, lower is the fertility of the state. The implied female education elasticity at the point of sample mean is 0.125 for total fertility. The point estimate implies that, at the sample mean, with a 1 per cent increase in the perception of women in a state with less than a primary level education is associated with a 0.83 per cent decline in fertility, and this decline is significantly different from zero.'[307] The NFHS-II found that contraceptive prevalence had increased from 41 per cent in 1992-93 to about 48 per cent in 1998-99, with female sterilisation being, of course, the mainstay of the programme. Unmet need for contraception is highest- about 27 per cent among women below the age of 20 years, this need is entirely for reversible and spacing methods. Unmet need is also high among women in the 20-24 years

[306] Ibid., p. 60.

[307] Ibid., p. 67.

age group, with about 75 per cent of this group needing spacing methods. The NFHS for 1998-99 also reveals that the TFR reflecting socio-economic deprivation is 3.15 for Scheduled Castes (SCs), 3.06 for Scheduled Tribes (STs), 2.66 among Other Backward Classes (OBCs) and 3.47 among illiterate women as a whole. In contrast, it is 1.99 among better of women educated beyond class 10. The NFHS reveals that the IMR among the SCs, STs, and OBCs was 83, 84 and 76 respectively compared to 62 among others. About 72 per cent of births among the SCs women and 81 per cent of births among the STs took place at home, compared to 59 per cent among others. Conversely, only 21 per cent of births among SCs and 18 per cent among STs women took place in a medical institute. Of the total home deliveries among SC and ST women, more than 40 per cent were attended to by the TBA or a *dāi*. Only 36 per cent of women among SCs and 23 of women among STs received the attention of public health personnel. Thus, the NFHS data clearly reflects socio-economic conditions and variations in other indices whether that may be mortality or contraception adoption. However, the unmet need for family planning is substantially higher among the poorer groups. This again refute the poor logic of neo-Malthusians that poor profligate.

Among the studies of the present decade, is the empirical study of the two districts of Andhra Pradesh undertaken by Neeraja[308] on a sample of 800 fecund women. The study mainly focused on correlating the maternal, child health and family planning services and concluded that types of services extended by the multi purpose health worker (female) is the lone variable

[308] K.P. Neeraja, *Rural Women- Maternal, Child Health and Family Planning Services* (New Delhi: Discovery Publishing House, 2003).

which has shown a significant influence on the family planning adoption. Overall a very poor adoption of contraception was observed in the study area and the reasons ranged from fear of side effects, need of more children to unwillingness of husband. However, study failed to look beyond the service delivery system in contraceptive adoption and other dynamics and determinants of family planning. In year 2004, came the brilliant critique (that reminds us of Bose 1988 humorous accounts) of hitherto population studies and family planning interventions by Mahon Rao[309] a much-awaited volume in wake of Cairo conference. The author has brilliantly tried to engage with ideas, exploring the contexts and the contradictions. His primary purpose has been to locate and critique the family planning programme in India, its assumptions, unstated biases, and implications. Author noted since everyone who matters agrees that population is the biggest social problem in the country, how is it that the family planning programme, one of the largest public health initiatives in the world, has consistently fallen short of its objectives? Even if one were to agree that the issue is bringing down growth rates for the good of the nation, are we approaching the problem as we ought to ensuring health and security to peoples lives? If not, why not? Accordingly to Rao we have posed the question incorrectly, and have thus come up with answers that have been seriously misleading, putting the metaphorical cart before the horse, in a country where the vast majority of people have, of course, neither cart nor horse. What has occurred therefore is that issues of health have not received the central attention they ought to have. Health has become divorced from levels of living, of condition of work, of access to food,

[309] Rao, *From Population Control to Reproductive Health : Malthusian Arithmetic.*

of striving for quality, and justice; it has come to be equated with doctors, hospitals, and technical interventions. Looking over the exhaustive and systematic criticism of changing (but unfruitful) strategies of family welfare programmes, especially under foreign influence, it seemed that author has negated the very relevance and utility of family planning. However, probably sensing the same, Rao himself (towards the end) noted, 'I am not arguing that family planning technology is not important, that people do not need it, that women in particular, do not seek it. On the contrary, my argument is that contraception is a right. It is a right as much as, and closely imbricated with, a right to health, a right to development, a right to security of our lives and our children's lives, and indeed a right to hope for the future?'[310] Author also pondered over the question- why some groups have more births than others? Could this have something to do with high death rates? What is the distribution of births and deaths among different segments of the population? When I looked for data on births, deaths and family size by socio- economic groups, I found very little that was worthwhile, reliable, and consistent. The truth of the matter, of course, is that we have not looked for better data, since we have not imagined it [italics mine]. Visaria and Visaria[311] came up with a more demographically sound and analytical paper outlining changing population dynamics since independence- be that population composition, fertility rates by age, household size, female headship, participation of women in economy, contraceptive prevalence, and more importantly population momentum (youth distribution in population) which impedes fertility decline.

[310] Ibid., pp. 269-70.

[311] Visaria and Visaria, "India's Population."

Santha[312] attempted to understand the dynamics of contraception adoption and made a thorough analysis of the NFHS-II data and outlined the areas of future research which includes among others- gaining a better understanding of how much women and men make choices and negotiate trade-offs among methods, research to understand why women discontinue use, and more importantly research on the attitude and practice of men regarding fertility regulation. There is another very important and recent empirical study[313] (published in 2006) which has used the Amartya Sen concept of 'well-being'[314] in studying the family planning adopters in rural Mexico and findings of the study are worth important to quote here. This rural Mexico study, based on a sample size of 300 women distributed across six communities of Chiapas in rural Mexico used structured questionnaire and some open questions about their pregnancies history, with their use of contraceptives, and their opinion of traditional gender roles and life expectations. The study has brilliantly dwelled on the process of sterilisation adoption- main reasons of adoption, extent of participation in decision-making, complications and also post-operation satisfaction or frustration to sterilised women. Their analysis demonstrated that women who positively assess their paid work outside the home and actually perform such work (the willingly employed category), generally have

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[312] Santha, "Contraceptive Use Dynamics."

[313] Beutelspacher, Martela, and Garcia, "Does Contraception Benefit Women? Structure, Agency and Well Being in Rural Mexico."

[314] Amartya Sen (1985) suggests that 'well being' is a combination of doings and beings that is functioning's that may large from being well-nourished and healthy to having self respect, human dignity and the ability to participate in community life. He assigns paramount importance to the freedom to choose between alternative functioning, which he terms as the 'capability to function' (Sen, 1988), that is, the freedom a person has for leading the life s/he values and achieving valuable functioning. Sen further stresses that we must pay attention to both the achievement of well being (achieved functioning) and well being freedom. See Amartya Sen, "Well Being, Agency and Freedom- the Dewey Lectures 1984," *Journal of Philosophy* 82, no. 4 (1985)., Amartya Sen, "Freedom of Choice, Concept and Content," *European Economic review* 32 (1988).

fewer children than those who greatly value their roles as mothers and wives (the willingly home-based category). Authors noted that choosing the contraceptive option is central to women's well-being. On the one hand, there can be conflict in the decision-making process between women's personal interests and those of the household, as well as in the distribution of benefits derived from such decisions. Finally, they concluded, our analysis demonstrate that there is no state forward relationship between the adoption of contraceptive methods promoted by state family planning programs, and an increase in the women's well being as defined by Sen. Several factors intervene in women's contraceptive choices, such as their educational levels, their assessment of paid work and their actual chances of getting such work. The contribution of these factors enhances the possibility of contraceptive use in increasing the women's well-being. In this sense, an examination of life options that rural communities offer to women is a key element in understanding women well being. Our analysis shows that local opportunities for education and paid work outside the home translate into stronger possibilities of women achieving well being. However, the study though pondered over the process and determinants of contraceptive adoption, fails to take full cognisance of the intra-house dynamics of communication and power relation (of which participation in decision making is one aspect) and cumulative effect of determinants other than employment pattern and education of women.

1.6 Justification of Study

The United Nations estimated the population of the Indian sub-continent (consisting of India, Pakistan, and Bangladesh), on 1 July 2000 as 1299 million, 1.1 per cent higher than 1284 million for China (including Hong Knog). Two of the oldest civilizations of the world together accounted for almost 43 per cent of the world population (6.1 billion) and 53 per cent of the population of the less developed countries (4.87 billion) and India is expected to exceed China's population some time during 2045-46, according to United Nations projections.[315] The 2001 Census of India counted down the total population of country as 1027 million.[316] It is also noted that decadal growth of population in India is more than the population of Brazil and that the population of one of its States, that is Uttar Pradesh (UP) is more than the population of near neighbour Pakistan.[317] With this brief demographic profile, the justification of the present research on personal and familial characteristics in the adoption of family welfare programmes begins with a question J.N. Sinha raised more than a quarter ago. Sinha[318] observed that the situation was well within control so long as the Malthusian devils of famines, epidemics and

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[315] Cited in Visaria and Visaria, "India's Population.", p. 61. However, on the eve of 2001 Indian Census completion, the Census Commissioner speaking at 'Population Trends in India: Migrating Towards New Realities' claimed that by 2050 India's population is estimated at 1528 million and will be larger than China's 1477 million population (Times of India, New Delhi, December 4, 2001). This reducing in the target year (from 2050 to 2045) in which India's population will exceeds that of China, further reflects the high growth rate of Indian population.

[316] GOI, *Women and Men in India 2001* (New Delhi: Ministry of Statistics and Programme Implementation, Government of India (GOI), 2002)., p. 2.

[317] Cited in Noor Mohammad et al., "Convergence Approach for the Promotion of Reproductive and Child Health: Learning from Lodha Block Experiences," *Indian Journal of Social Development* 3, no. 1 (2003)., p. 106.

[318] J.N. Sinha, "What Price Population?," in *Studies in Demography- Essays Presented to Professor S. Chandrasekhar on His Fifty-First Birthday*, ed. Ashish Bose, P.B. Desai, and S.P. Jain (London: George Allen and Unwin, 1970)., pp. 431-433.

wars were in action. But what is the price that we have to pay for chaining these devils? He further cautioned at present many physiological and cultural factors keep Indian fertility below the biological limits. Malnutrition, early maternity, neglect of women, ban on widow remarriage[319], prolonged lactation after child birth and the practice of young wife staying with her mother- all inhibits fertility. *What of future*? [Italics mine] The answer to this question today, nor at any time, definitely does not lie either in unleashing Malthusian devils or in any recourse to past practices just mentioned. It is here that Davis very carefully and cogently noted that there is no reason to abandon family planning programme, *contraception is a valuable technological instrument* [italics mine].[320] It is this increasing importance of contraception that paves the way for the present research. The historical data abounds the explanation for the fertility differentials between different social groups. With Malthusian pessimism the very notion of positive relationship between population growth and nation's development was put under the heaps of dust. What spread like wild fire is the assumption that the poor are prone to profligacy and high fertility – an impediment to growth and development of society? Thus the generations of scholars and researchers devoted themselves in understanding the various shades of fertility determinants. The fertility calculus was put to social and occupational differentiations.[321] In India 'since the early 1960s

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[319] According to Visaria and Visaria an important post-Independence change in the composition of the population as regards marital status has been the decline in the incidence of widowhood, because of the decline in mortality. The per centage of widows enumerated by the Census has declined from 10.8 per cent of all women in 1961 to 6.5 in 1991. See Visaria and Visaria, "India's Population.", p. 71.

[320] Davis, "Population Policy: Will Current Programs Succeed?.", p. 395.

[321] For example Arsene Dumont noticing widespread differences in fertility between different social groups attributed them to what he called ***la capillaire sociale***. In this social capillary theory he made the fundamental observation that the prosperous groups in order to raise socially and to enable their children to do so, tended to have fewer children while peasant

there has been a spate of empirical studies on fertility determinants.'[322] However, Rao[323] excellent bibliography of 550 studies on fertility, family planning and contraceptive practice during 1951-74 lamented that only a miniscule (11) number are informed of the importance of social differences in fertility. Of these 11 studies, the majority uses the caste or education as the basis of stratification. The much ill famous Khanna study[324] visualized high fertility and 'over population as malady of society that produces wasted bodies, minds and spirits.' Mamdani who also studied the same area as the universe of Khanna study justified the 'large families of peasants as rational given the socio-economic conditions.'[325] Nadkarni observed the persistence of 'large families among cultivators than non cultivators but among cultivators, the size of family among poor is smaller.'[326] Ansari in his study also qualified the same by analyzing the households as both unit of consumption and production and those that are only unit of consumption. 'The size was largest in units where production held the family together 4.71, while it was lower in household units which are primarily units of consumption: 4.54.'[327] Similarly Mysore study[328], Uttar Pradesh study by Mishra[329] *et. al* and Rao[330] study of

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families not only lacked these negative inducements against children but felt a positive inducement for them. Similarly Alfred Marshall pointed out that different occupation groups within the labouring classes differd markedly in their behaviour and thus pioneering the so-called labour theory of fertility. For details see Rao, *From Population Control to Reproductive Health : Malthusian Arithmetic.*, p. 125.

[322] Patel, *Fertility Behaviour.*, p.1.

[323] Rao, *Studies in Family Planning: India.*

[324] Wyon and Gordon, *The Khanna Study : Population Problems in the Rural Punjab.*, p. 21.

[325] Mamdani, *The Myth of Population Control : Family, Caste, and Class in an Indian Village.*

[326] M.V. Nankarni, ""Overpopulation" and the Rural Poor," *Economic and Political Weekly* 11, no. 31-33 (1976).

[327] Rashid A. Ansari, "Poverty Ocuupational Groups and Family Size among Agriculturalists and Weavers of Tanda Tehsil, District Faizabad" (Jawaharlal Nehru University, 1994). Cited in Rao, 2004, pp. 147-148.

[328] U.N., "The Mysore Population Study."

Karnataka, all have found higher birth rates among the primarily exploiting and higher socio-economic groups, namely landlords and rich peasants. Rao[331] categorically argued that it is not cultural factors or traditions that determine levels of fertility but objective socio-economic factors such as the nature of livelihood and chances of child survival. The National Family Health Survey (NFHS)-II[332], though concludes high fertility among poor, too recognizes that household with a low standard of living have infant and child mortality rates two or three times higher than households with high standard of living. What is common in majority of these studies is monotonic, uni-variable and uni-directional linkage between fertility and its determinants. Sen[333] rightly argues that 'Malthusian pessimism takes attention away from investigating what prompts people to make the fertility decision they make and how these choices depend on the large number of material and other conditions within which they live and work.' Khan[334] very rightly noted that all human behaviour is governed by the social and cultural milieu and reproductive behaviour is no exception. It is also regulated by persisting norms, values, customs and taboos of society. Rao[335] also argues that the 'major problem with plethora of studies is that they tells about certain

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[329] B.D. Mishra et al., "Family Planning in Uttar Pradesh: A Change Programme and Its Clients," (Kanpur: Indian Institute of Technology, 1973).

[330] Mohan Rao, "An Investigation into the Differential Behaviour of Economic Classes in Relation to the Family Planning Programme in Mandya District, Karnataka" (Jawaharlal Nehru University, 1995). Cited in Rao, 2004, pp. 147-148.

[331] S.K. Rao, "Population Growth and Economic Development: A Counter Argument," *Economic and Political Weekly* 11, no. 31-33 (Special Number) (1976).

[332] International Institute for Population Sciences., *National Family Health Survey (Mch and Family Planning) India, 1992-93* (Mumbai: International Institute for Population Sciences, 1995).

[333] Sen, "Population and Reasoned Agency: Food, Fertility and Economic Development."

[334] Khan, *Family Planning among Muslims in India.*, p. 1.

[335] Rao, *From Population Control to Reproductive Health : Malthusian Arithmetic.*

associations ignoring other factors that are equally significant.' Thus, the major limitation of these studies is inability to cross classify multiple determinants of fertility. More recently Patel[336] highlights the major gap in past studies and stressed heavily on exploring the specific institutional mechanism through which socio-economic factors (so called major determinants of fertility) operate, and linking the objective conditions of life with people's subjective orientation to understand the most intimate of human behaviour i.e. fertility behaviour.

Furthermore, it is interesting to note that almost all the major Indian studies on fertility and family planning abruptly ends at fertility decisions, failing to take cognisance of further interplay of intra-house dynamics of communication and power relation in the contraceptive adoption. There is much more to explore and to understand the inter play of forces in between i.e. after the 'rational' fertility decision, and before the contraceptive adoption. Further, given the collective nature of Indian society every actor and his actions are socially conditioned of which contraception is no exception and hence an urgent need to review and explore the personal and familial characteristics on one hand and intra house dynamics of communication of power relation which together conditioned the process of contraceptive adoption. More interestingly, the champions of family planning (irrespective of differences in their shades) all dovetailed to indiscriminately focus on 'enlightened individual wisdom'[337] to

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[336] Patel, *Fertility Behaviour*.

[337] Interestingly, there are studies such as those of Hawthorn who in their attempt to explain the social determinants of fertility, stresses that the explanation of fertility behaviour must begin with the individuals. He believes that the attempt to explain the fertility pattern have suffered by too little concern with individual reasons for their behaviour and too much

make use of multiple innovative family planning and reproductive technologies and thus to contribute in population control and nation's development and in this race completely ignored Indian social matrix. G.R. Bannejee[338] renowned social work scholar observed that western society is far more individualistic, whereas, role-definition in India requires a person to be 'duty' oriented towards their family, community and only least at all, to themselves. Noted sociologist Kingslay Davis also qualified the above observation and noted:

> Unfortunately, the issue is confused by a matter of semantics. "Family planning" and "fertility control" suggest that reproduction is being regulated according to some rational plan. And so it is, but *only from the standpoint of the individual couple, not from that of the community.* What is rational in the light of a couple's situation may be totally irrational from the standpoint of society's welfare. .....The need for societal regulation on individual behaviour is readily recognized in other spheres- those of explosives, dangerous drugs, public property, natural resources. But in the sphere of reproduction, complete individual initiative is generally favoured even by those liberal intellectuals who, in other spheres, most favour economic and social planning [italics mine].[339]

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concern with superficial similarities in their circumstances. See G. Hawthorn, *The Sociology of Fertility* (London: Macmillan Ltd., 1970).

[338] G.R. Bannejee, *Papers in Social Work Education: An Indian Perspective* (Bombay: TISS Publication, 1972). Later in 1990 Farida Kassim Ejaz, who analysed the concept of familial duty and its implications for social work practice in India, noted that the concept of duty and the role obligations of men and women pervades Indian tradition to other religious groups as well. See Farida Kassim Ejaz, "The Concept of Familial Duty in India: Implications for Social Work Practice," *Indian Journal of Social Work* LI, no. 3 (1990)., p. 437.

[339] Davis, "Population Policy: Will Current Programs Succeed?.", p. 389.

The present research aims to revisit family welfare programmes but from their roots i.e. Indian social milieu. The study thus attempts to fill this gap and to overcome such inherent limitations of studies on fertility and family planning. The study focuses on the multiple determinants of fertility and adoption of family welfare programmes and the social institutions through which these determinants operate and put to practical and subjective realms. The family is taken as the most pervasive of all social institutions[340], given the collective nature of Indian society in which family regulates the seamless but subtle relationship between individual and the society[341]. It is rightly noted that a family in India, as elsewhere, is a corporate group whose members act together to meet their common purpose. Each person learns the fundamentals of his culture and society from his family[342]. Mandelbaum further cogently noted 'every social system, whether relatively complex or simple, rests on these natural systems (i.e. biology and ecology). These natural systems can be called parasocial system in the sense that they constantly and directly impinge on social relations. .....As for biological factors, the consequences of the new social controls over diseases have been much discussed in the demographic literature and need only to be mentioned here. These controls

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[340] For example Desai noted that among the institutions that compose rural society, the family is the most important. It has been its very foundation. It plays a decisive role in the material and cultural life of the rural aggregate and in moulding the psychological characteristics of the rural individual as well as the rural collectively. He, however, also commented on the undergoing qualitative transformation and the fact the rural society is acquiring quite a new gestalt. A.R. Desai, *Rural Sociology in India*, (Reprint 2006) Fifth ed. (Bombay: Popular Prakashan, 1978)., p. 31, 37.

[341] George Peter Murdock, for example, concludes (in *Social Structure*) on a sample of 250 societies that 'the family's functions for society are inseparable from its own functions for its individual members. It serves both at one and the same time and in much the same way.' For this and more critical views on the institution of family see chapter 8: The Family in M. Haralambos and R.M. Heald, *Sociology- Themes and Perspectives*, Twenty-ninth impression (first published in 1980) ed. (Oxford: Oxford University Press, 2006)., p 331.

[342] David G. Mandelbaum, *Society in India*, Indian Edition in One volume 2005 reprint ed. (Bombay: Popular Prakashan, 1970)., p. 41.

have been made possible by the mega social system of medical science and have been mainly implemented by governmental agencies. *Their success makes necessary new social adaptations of many kinds, a principal one being for greater controls over the biological forces of procreation* [addition and italics mine].'[343] Family, thus, can provide the threshold energy needed for this social adaptation by promoting small family norm and contraceptive adoption. The 'Indian family' is the unique social institution in which and through which socio-economic determinants of fertility decision and family welfare programmes adoption operate.[344] Unfortunately, even in all the government programmes on family planning, now family welfare, focus remains on individual 'couple' instead of 'family'. Desai survey of literature has shown that 'the government has acknowledged "small family norm" for family planning programmes, without at all defining *what is a family. The world family is nowhere defined*[345] [italics mine].'[346] Interestingly, the item 3.1 of the Report of the Committee on Small Family Norm states 'the responsibility of the couple to their children and society at large has to be invoked. In large measure, appeals about the happiness and welfare of the family and children

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[343] Ibid., pp. 405-409.

[344] For example Patel noted that there are socially prevalent notions about when to begin, when to end, and how many children of what sex are ideal to have. The response of the significant others means a lot to the mother, as does her fertility performance to the family and the community. See Patel, *Fertility Behaviour.*, p. xxvii.

[345] Similarly, Bose noted that the population control programme is called mistakenly as the family planning programme because the family is nowhere in the picture. See Bose, *From Population to People.*, p. xiii.

[346] Desai, *Urban Family Planning in India.*, pp. 8-9. He even argued that 'the adoption of the concept 'couple', based on individual *per se* is most convenient and handy one for the ruling class, which is not interested in developing family planning programme basically to make it acceptable by families for either enhancing the efficiency of the family to perform its specialised functions properly or to enhance family welfare. .....The government finds the concept 'couple' instead of family shorn of its social attributes very convenient in its family planning programme because it provides an excellent weapon in the hands of the government, to directly encroach on the private life of the individual'. (pp. 147-148).

have to be made so that individuals may perceive a small family to be in their personal and familial interests.'[347] In the very year in which 'small family norm committee report, saw light of day (1968), the eminent sociologists, Bell and Vogel, unlike our policy makers, have defined family in terms of family's relation to larger society and as an institution preserving the value system of society. According to them, 'the nuclear family's internal activities and functions they serve are always internally related to the position of family in society.'[348] They spelled out in detail 'the interaction and intercourse of family (nuclear family) on the one hand and economy, polity, community and value system in general on the other.'[349] They further wrote that 'the significance of the nuclear family, with regard to the society's value system stems from the fact that the nuclear family is the smallest social unit responsible for the preservation of the value system.'[350] Ramkrishna Mukherjee[351], very rightly suggested to 'examine the issue of family planning in the conceptual and empirical perspective' and also observed that 'the concept 'couple' chosen as a unit and identified with the concept 'family', for family planning movement, ignores the role of family as a sociological entity.' He warned that such a concept is of dreadful implications and pointed that even some of important 'studies did not usually take into account the possible consequences of difference in the unit of sampling and unit of observation.

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[347] Govenment of India Department of Family Planning, "Small Family Norm Committee Report," (New Delhi: Ministry of Health, Family Planning and Urban Development, 1968)., p. 7.

[348] Bell and Vogel, *A Modern Introduction to the Family* (New York: The Free Press, 1968)., p. 9.

[349] Ibid., p. 10.

[350] Ibid., p. 19.

[351] Mukherjee, *Family and Planning in India.*, pp. 17-18.

The unit of sampling is family and unit of observation is a couple.'[352] Thus, it is unfortunate that in most discussions on family planning, the family is never discussed.[353] Such an understanding and heavy reliance on individual couple in as intimate a matter as family planning, clearly smacks either the foreign influence[354] (read pressure) or poor understanding of Indian society by the 'enlightened elite Indians', who are the vanguards of policy and planning. It is indeed like 'putting the metaphorical cart before the horse.'[355] It is this limited understanding (rather misunderstanding) of family-couple gestalt that has resulted in the programme failure, irrespective of high value results of KAP (Knowledge, Attitude and Practice) studies[356]. It is rightly said that 'there is no reason to abandon family planning programs; contraception is a valuable technological instrument. But such programs must be supplemented with equal or greater investments in research and experimentation to determine the required socio-economic measures.'[357] Talwar[358] also argued that since the wide practice of family planning method is the only solution to bring about

[352] Ibid., p. 16.

[353] Bose, "The Family Welfare Programme in India: Changing Paradigm.", p. 2.

[354] It is observed that the philosophy behind the programme was based on a western model (under the influence of the donor agencies). See Bose, *From Population to People.*, p. xiii.

[355] The phrase borrowed from Mohan Rao's eloquent description of Indian government approach to deal with health and family planning. See Rao, *From Population Control to Reproductive Health : Malthusian Arithmetic.*, p. 14.

[356] A great many reviewers have made sarcastic observations of KAP (surveys) 'gap'. Hauser even opined many of the KAP 'facts' are erroneous. He supported his judgement 'by the gap between the 70 per cent plus response to KAP survey question on "interest in learning" about birth control and relatively small per centage of "accepter" of clinic services offered *gratis* by present action programs- frequently at levels of 7-10 per cent. This gap certainly raises serious questions about both the validity of the survey response and the assumption of rational behaviour.' See Philip M. Hauser, "On Non-Family Planning Methods of Population Control," in *Studies in Demography- Essays Presented to Professor S. Chandrasekhar on His Fifty-First Birthday*, ed. Ashish Bose, P.B. Desai, and S.P. Jain (London: George Allen and Unwin, 1970)., pp. 356-357. Equally critical of KAP surveys were other contemporary and even present researchers. For details of each type see, Mitra, "Population in India's Development.", and Rao, *From Population Control to Reproductive Health : Malthusian Arithmetic.*

[357] Davis, "Population Policy: Will Current Programs Succeed?.", p. 395.

[358] Talwar, "Determinants and Consequences of Rapid Population Growth.", p. 57.

substantial changes in the birth, the obvious questions is – how can the use of family planning methods be increased. More recently outlining the key research areas Santha[359] noted 'gaining a better understanding of how women and men make choices and negotiate trade-offs among methods could provide useful insights for policy makers, programme managers as well as clients themselves. Future research should explore the context in which women and men exercise choice, including the power dynamics of relationship, and the interface between clients and the service system.'

In the light of discussions in this chapter it may safely be inferred- that population growth needs to be urgently curtailed; that government has experimented a dozens of strategies in more than a half century endeavour; that both unmet needs for contraception and mass inertia to family planning exists; that contraception is a valuable technology; that individual/couple centric approach is indigestive in rural milieu; that a plethora of studies have pondered over socio-economic determinants of fertility behaviour and family planning adoption; that few have explored the cultural context and constraints; that communication studies of contraceptive adopters have focused too much on source rather than the object (our subject).

The more specific questions to cogently circumnavigate these issues are- who are the adopters; how they trade-off the journey from fertility decision to contraceptive adoption; how the intra-house dynamics of communication and power relations matters in the process of adoption . In this backdrop,

[359] Santha, "Contraceptive Use Dynamics.", p. 43.

understanding and exploring the dynamics of personal and familial characteristics in the adoption of family welfare programmes is the central objective of the present study.

CHAPTER-2

RESEARCH METHODOLOGY

CHAPTER-2

Research Methodology

2.1 Research Design

The present research is a micro exploratory study of the adoption of family welfare programmes. However, before proceeding it is necessary to have an overview of the broad theoretical positions in fertility studies on the one hand and social work intervention levels and perspectives on the other, so as to outline the framework of present research. Patel[1], on examinations of fertility studies, finds four prominent trends: macro-structural, micro economic, psycho-social, and socio-economic and also noted that Demeny[2] classifies macro structural and socio-economic studies under 'general socio-economic studies' and within this broad category made distinction between the macro- and micro-level. Patel's further discussion of these seems to present two broad regroupings i.e. macro studies (macro-structural and socio-economic) and micro studies (micro-economic and psycho-social). The former assumes the dominance of social structural and socio-economic factors in constraining fertility outcomes of passive or docile couples and their analyses of fertility differentials are scarcely concerned with the purpose of human agents and their subjective orientations. While the latter, views fertility behaviour as a

[1] Patel, *Fertility Behaviour.*, pp. 1-3. Much of the discussion on fertility models is most humbly quoted from these pages.

[2] P. Demeny, "Research on the Determinants of Fertility: A Note on Priorities," *Population and Development Review* 7, no. 2 (1981)., cited in Patel, *Fertility Behaviour.*, p. 2.

result of factors that actors comprehend and control. In other words, couples on the basis of their knowledge and assessment tend to 'make happen' a given fertility pattern. Thus, while one over-emphasizes the calculative knowledge of couples, the other remains silent about the day-to-day social activity of reproductive agents. Patel concludes that overall these focus on the subjective orientations of actors or on the broad objectives/structural features of the society circumventing fertility behaviour. In this backdrop the researcher contention is to focus on institutional mechanisms through which both subjective and objective realms are made operative.

The present research focuses on these institutional mechanisms, and given the collective and unique nature of Indian rural family, as a social institution, the family is taken as a unit of study. Further, the collective value system of Indian society, ethos and community solidarity are preserved and mutates through the institution of family, of which fertility behaviour and adoption of family welfare programmes are no exceptions. It is also noted that 'the family as a unit is the best compromise between a macroscopic unit like society and microscopic unit like the individual- it contains the essence of both'[3]. There is another significant reason for taking 'family' as a unit of study and the answer lies in values of social work in India. A more recent model in social work, that is generalist social work, 'focuses on intervention at all system levels. The definition of the problem, issue, or need, *not the method alone*, determines the strategies that social workers and clients select.'[4] Dubois and Miley further

[3] Khan, *Family Planning among Muslims in India.*, p. 13.

[4] Brenda Dubois and Karla Krogsrud Miley, *Social Work an Empowering Profession*, Third (first published 1992) ed. (Boston, London: Allyn and Bacon, 1999)., p. 71.

noted that 'social work clients may be at any level in the social systems continuum- at the microlevel, individuals, families and groups; at the midlevel, formal groups and organizations; at the macrolevel, community, society, or even the world community; and even the professional system of social work.'[5] Social work profession in India still struggles against accusations that it is a western transplant (legacy of American professional social work)[6] and that there is a need for 'indigenisation of social work'.[7] Very recently, Desai noted, 'the ideologies of professional social work in India have had to face some similarities and some contradictions with reference to the Indian ideologies, based in its social ethos, religions and indigenous social movements. *The Indian society is structured by families and communities, whereas, the western social work approach is individualistic.* The ideology of Indian social work profession today seems to have evolved as a combination of focus on individuals, families and communities [italics mine].'[8] However, the generalist social work's focus on social system continuum and micro level units of interventions make the 'family' as best fit unit of study in Indian society which also resonates with the 'global social work perspective'[9].

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[5] Ibid., p. 71.

[6] Murli Desai, *Ideologies and Social Work- Historical and Contemporary Analyses, Subject Curriculam Series for Social Work Education* (Jaipur and New Delhi: Rawat Publications, 2002)., p. 136.

[7] On this issue P.D. Kulkarni observed 'there has been an almost non-stop cry- rather exaggerated, if not some what misplaced- for indigenisation of social work teaching and social work practice in India. There is a constant accusation of our being heavily dependent upon imported models, techniques, literature, and so on.' He strongly noted 'I do not wholly agree with this charge'. P.D. Kulkarni, "Teaching of Social Sciences in Schools for Social Work," *The Indian Journal of Social Work* 61, no. 2 (2000)., p. 193, 195. Also see P.D. Kulkarni, "The Indigenous Base of Social Work in India," *The Indian Journal of Social Work* 54, no. 4 (1993).

[8] Desai, *Ideologies and Social Work- Historical and Contemporary Analyses.*, p. 137.

[9] To my limited understanding of the subject, social work profession with its client centred approach (which is much quoted as a reason for its indigenisation) has developed (rather evolved) a specialised body of knowledge and skills which are intrinsic to social work practice

Hence, the family as unit of study takes the present research more close to Indian model of social work instead of western social work unit 'individual' and family welfare programmes much-criticised unit 'couple'. Thus, from social work perspectives, as well, the present research is a micro level study.

Thus in the light of insight gained from literature review and the outlined justification of the study and research design, the present research proceeds to achieve the following objectives.

Objectives

The central objective of the study is to explore the dynamics of personal and familial characteristics in the adoption of family welfare programmes. That is to understand how the personal and familial characteristics first become operative (if any, under the influence of socio-economic variables) and than operates (through intra-house dynamics of communication and power relations within the family) to determine the very process of contraceptive adoption. A number of studies have shown the importance of socio-economic variables and rural reproductive pattern in fertility decisions and contraceptive adoption. Here endeavour is to see how these much acknowledged variables stimulate the personal and familial characteristics, which in turn determine the process of contraceptive adoption. Thus study focuses on the following objectives:

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any where in the world. I dare to say that social work profession's foundations are global in nature and like any other disciplines and professions; it has an element of adaptability to be effective locally. More recently, with globalisation as watch word, researchers have started pondering over the issue of internationalising social work education to respond adequately to emerging global changes, issues, needs and problems. Specific reference here may be made of an article- David Cox, "Internationalising Social Work Education," *The Indian Journal of Social Work* 61, no. 2 (2000).

1. To analyse and assess the influence of socio-economic correlates, and the personal and familial characteristics in the adoption of family welfare programmes.

2. To analyse the nature and impact of rural women reproductive trajectory in the adoption of family welfare programmes.

3. To explore the intra-house dynamics of communication and power relations in the adoption of family welfare programmes.

4. To understand how personal and familial characteristics operate to influence the process of contraceptive adoption.

Hypotheses

In the light of objectives, following hypotheses are posited for verification in this study-

1. Higher the caste, education, income and outside employment, higher the adoption of family welfare programmes.

2. Poorer the reproductive trajectory of woman, poorer the adoption of family welfare programmes.

3.1 Higher the scope of discussion on family issues (wider the communication domain), higher the adoption of family welfare programmes.

3.2 Higher the mutual decision making in family, higher the adoption of family welfare programmes

4.1 More positive the personal and familial response to contraceptive methods, more the adoption of contraceptives.

4.2 More participatory the decision making process, more the adoption of contraceptives.

2.2 Universe and sample selection

The present research focuses on analysis of Lodha block[10], which lies in Aligarh district, Uttar Pradesh (henceforth UP). UP lies in the north zone of India (see Map 1[11]) and is most populous state of India and falls in the category of BIMARU states. BIMARU is an acronym used by Ashish Bose for four demographically poor performing states and hence stands in alphabetical order for Bihar, Madhya Pradesh, Rajasthan and Uttar Pradesh (*BIMARU*). Bose himself noted these four states are truly sick (*'bīmāru'* in eastern Hindi dialect), demographically, socially, economically and politically. Bihar is the picture of anarchy. UP situation is not better than Bihar.[12] Bose further clears the comparative picture and has shown that the population of *BIMARU* states will increase from 39.6 per cent in 1991 to 51.4 per cent in

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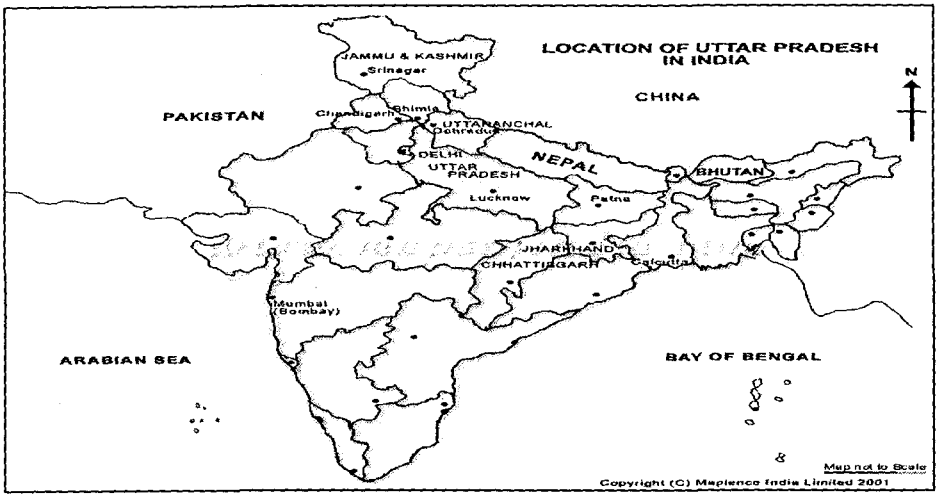
[10] Block in India is a development unit below the district and above the village. In India, all the development programmes and schemes are executed from these development blocks. However, it is different from sub-district, which is called *tehsīle* and is a revenue and administrative unit. Thus, hierarchy from village may be constituted as village, block, *tehsīe* and district.

[11] Map 1 is taken from- http:// www.mapsofindia.com/Census2001/population/uttarpradesh.gif accessed on November 13, 2006.

[12] Bose, *Beyond Demography- Dialogue with People.*, p. 151.

2051 while the population of the southern states will decrease from 23.2 per cent in 1991 to 16.5 per cent in 2051.[13]

Map 1: Location of Uttar Pradesh in India



The pathetic demographic condition of UP is equally evident from the report of Registrar General's Expert Committee on Population Projections. Assuming that a Total Fertility Rate (TFR) of 2.1 per woman will pave the way for population stabilisation, the committee made the projections shown in table 2.1.

Table 2.1: Year by which Projected TFR will be 2.1 in selected States

States	Year
South	
Kerala	1988
Tamil Nadu	1993
Andra Pradesh	2002
Karnataka	2009
North	
Rajasthan	2019
Bihar	2039
Madhya Pradesh	Beyond 2060
Uttar Pradesh	Beyond 2100

Source[14]: Registrar General's Expert Committee on Population Projections, 1997

[13] Ibid., p. 151.

These projections further highlight the poor performance of UP in population stabilisation process. The condition of UP has further worst in other indices as well. The table 2.2 shows the comparative profile of India, Kerala (the model Indian State to have first achieve the below replenishment level of population growth) and UP (State in which lies the study area).

Table 2.2: Comparative profile of India, Kerala and Uttar Pradesh (UP)

1. Country /State/ District/ Block	2. Population (in Million) Census 2001	3. Annual Exponential Growth rate 1991-2001 (%)	4. Literacy Rate (% Female) Census 2001	5. Sex Ratio Census 2001	6. CBR SRS 2003	7. CDR SRS 2003	8. Natural Increase (CBR-CDR)	9. IMR SRS 2003	10. TFR SRS 1997	11. Mean age at effective marriage (Female 1997)	12. CPR (%) 31.3.2000
India	1027	1.70	54.16	933	25	8.1	16.9	64	3.3	19.5	46.2
Kerala	31.38	1.05	87.86	1058	6.8	6.4	0.4		1.8	22.0	39.6
UP	166.05	2.2	42.98	898	31.6	9.7	21.9	80	4.8	19.6	38.0

Source:
1. Col. 2-5, GOI (Ministry of Statistics and Programme Implementation) (2002) *Women and Men in India 2001*, New Delhi: Central Statistical Organisation, pp. 4, 80.
2. Col. 6-9, *SRS Bulletin on Vital Statistics*, October 2003
3. Col. 10-12, GOI (MOHFW) (2000) *Major Schemes and programmes*, Part-II Department of Family Welfare, Chapter- 29 National Family Welfare Programme, *Revised Edition (November)* p. 177. *Also see http//: www.mohfw.nic.in*

Thus UP has performed poorly in almost all parameters and as table 2.1 and 2.2 show it is worst in the country in terms of fertility rate although CPR reaches near to that of Kerala. As per Census 2001 results, UP still has as much as 97942 (against 112804 in 1991) villages- of which 16.77 per cent are with just 200 or less population, more than 50 per cent have sex ratio of 900 or less, just 10.66 per cent villages have literacy rate of 60 per cent and above and in case of female literacy the percentage of villages in the 60 and above

[14] Cited in Ibid., pp. 153-154.

literacy rate category is only 3.52 per cent.[15] In terms of districts also, UP have as much as 70 districts with wide spatial variations.

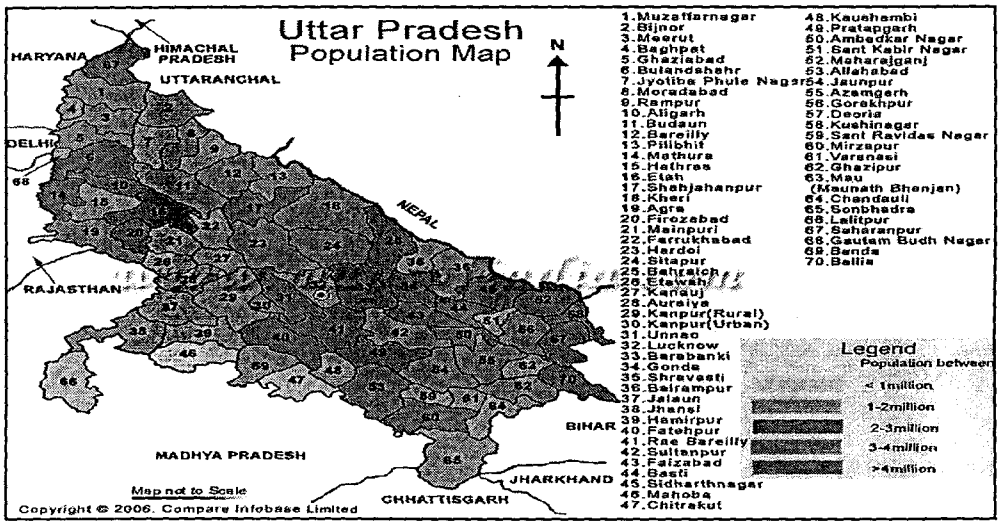
Aligarh with a population of 2.99 million[16] is one of the seventy districts of UP and is located at 27.30 N latitude and 79.40 E longitude on the western part of UP (see Map 2). It is at a distance of 180 km from New Delhi (India's capital city). The national highway (NH-83) connects Aligarh to Delhi. Aligarh is known across the world for its lever pad locks industry. In India it has largest cluster of lock manufacturing units. Aligarh district is divided into six sub- districts (*tehsīle*) and 12 blocks (see Map 3). The study area Lodha comes under *tehsīle* Koil and is one of the twelve blocks of Aligarh District. Lodha is located on three sides of Aligarh city (see Map 4) and have worst vital statistics in the district and due the same reasons, a project entitled *Convergence Approach for the Promotion of Reproductive and Child Health in Lodha Block, Aligarh District* (hereafter RCH project) was launched in the year 2000 initially for a period of two years and latter extended for another two years to end in December 2004. The agencies, State Innovations in Family Planning Services Project Agency (SIFPSA) and Population Foundation of India (PFI) funded the project. The Department of Sociology and Social work, Aligarh Muslim University (AMU), Aligarh implemented the project. One can also understands the poor reproductive health profile of Lodha block from the fact that in year 2001-2002 it has lowest sterilisation and against the target it achieved only 35.29 per cent and situation was even worst in 2002-2003 as it

[15] Selected citations from Census 2001 results. See GOI, *Census of India 2001: Cd-3 (Uttar Pradesh)* (New Delhi: Registrar General of India, Directorate of Census Operations, Government of India, 2001).

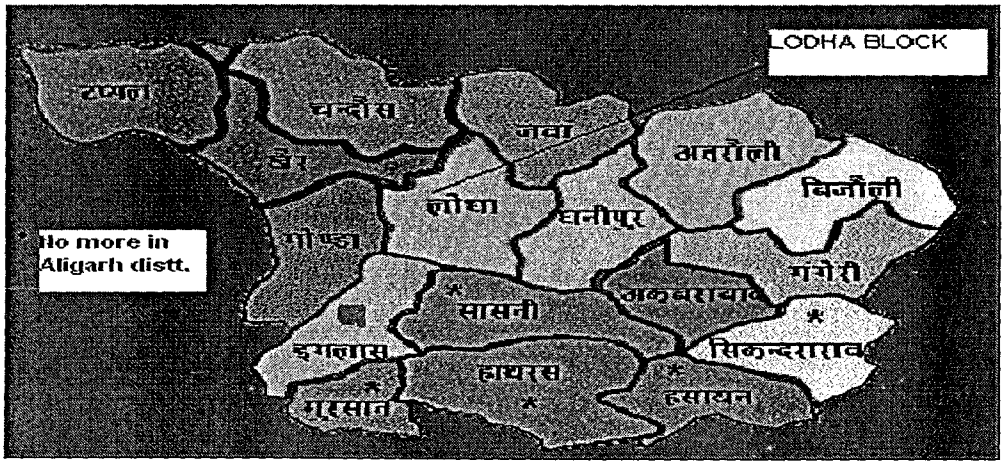
[16] Ibid.

achieved only 29.12 per of the sterilisation targets while there were also blocks in Aligarh to have more than cent per cent against the targets.[17] Furthermore and most importantly, the researcher brief involvement in the RCH project and related other field experiences while supervising the social work students in the same block resulted in taking Lodha as a unit of study in the present research.

Map 2: Uttar Pradesh (UP) and its Districts



Map 3: Aligarh District and Blocks



[17] District data presented as a part of Agenda for 4th AGM of DIFPSA (District wing of SIFPSA).

Sample selection

Lodha block as per Census 2001[18] has a population of 200642 scattered in 92 *Gram Panchayats* and 142 villages, out of which 136 are revenue villages and rest 6 are without habitation. Lodha has sex ratio of 848 females per thousand males, which is below the national and state average. As per the end term evaluation of RCH project in December 2001[19] the eligible couples in Lodha were 27564 with a CPR (Contraceptive Prevalence Rate) of 38.5 per cent. In terms of health administration, Lodha has one PHC (Primary Health Centre), more recently three more additional PHCs are established, and 28 sub-centres. One of these sub-centres is Jalalpur. Jalalpur sub-centre covers four villages namely Alapur Garhia, Ashrafpur Jalal, Alahadadpur Nivry and Rorawar (see Map 4). All together these villages constitute a population of 10091 in the coverage area of Jalalpur sub-centre.[20]

Thus, against the norms of a sub-centre at 5000 populations in plain areas, the population coverage of Jalalpur sub-centre is too large.[21] It may be noted that against the population norm of PHC at 30000 population Lodha has more than six times larger population coverage (that is 200624 population at one PHC). However, noting the reverses, more recently three additional PHCs are

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[18] The block level data as per Census 2001 are derived from Records of Block Development Office, health statistics at Primary Health Centre (PHC) at Nehra and office of ICDS at block headquarters.

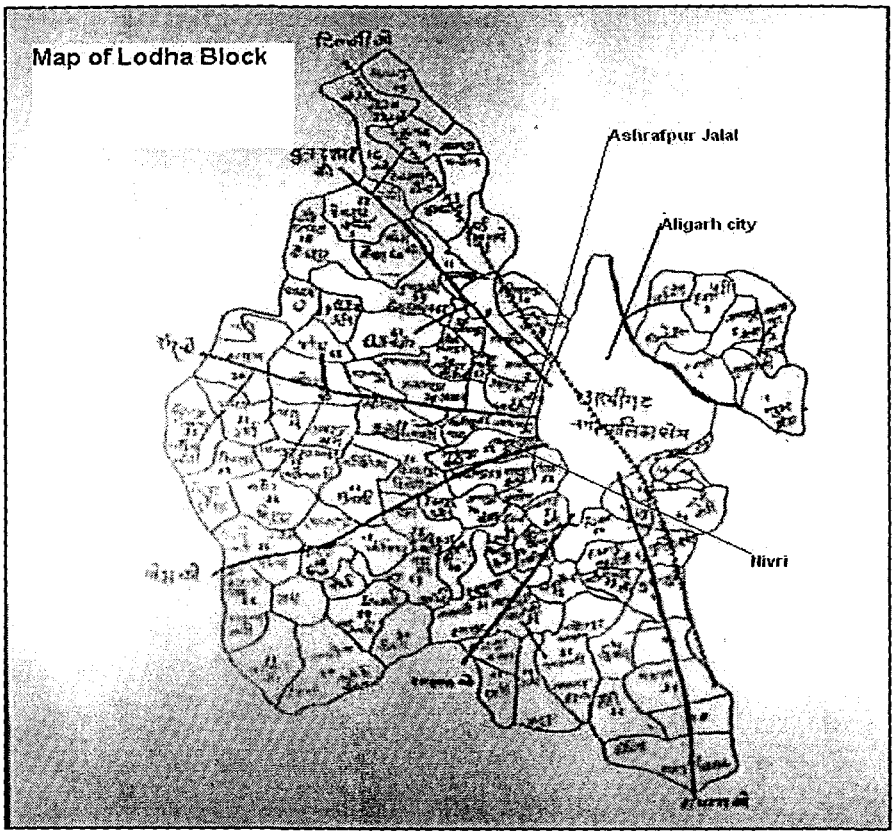
[19] It refers to data from RCH project in Lodha.

[20] GOI, *Census of India 2001: Cd-3 (Uttar Pradesh)*.

[21] As per Government of India (GOI) notification, the primary health care structure in the country has been established as per the following norms: Sub-Centre at 5000 population in plain areas and at 3000 population in hilly/tribal areas; PHC at 30000 population in plain areas and 20000 in hill and tribal areas and the CHC at 120000 population in plain areas and 80000 in hilly and tribal areas.

established to supplement the Lodha PHC at Nehra and along with that three sub-centres are also provided with an additional RCH worker[22] to supplement the task of Auxiliary Nurse Midwife (ANM).

Map 4: Lodha Block and villages



The Jalalpur sub-centre is one of those three sub-centres to have an additional RCH worker. Further the Jalalpur sub-centre has a sex ration of 849 and with an average household size of 6.26 person. The sub-centre Jalalpur owing to its proximity with the block headquarters and quick access to city is a centre of many project offices and organisations. Moreover, in the year 2005-2006 (April- March) it has highest number of sterilisation done (24 in number) in

[22] These RCH workers are appointed on basis in Category "C" districts where the status of RCH is poor and the infrastructure, roads and electricity is also generally weak, the task of the ANM is more difficult. See GOI., "National Family Welfare Programme.", p. 145.

comparison to other sub-centres. The profile of sterilisation cases in Jalalpur across two decades is given in table 2.3.

Table 2.3: Profile (Average) of Sterilisation cases under Jalalpur sub-centre

Profile of cases (Average)	1995-2005	1985-1995
Sterilisation cases	19.4	7.5
Average age at sterilisation	30.4	32.2
Average parity at sterilisation	3.95	3.57
Son-Daughter Alignment	2.43 + 1.52	2.17+ 1.40

Source: Auxiliary Nurse Midwife Sterilisation Cases Record Register, 1985-2005

As the table shows that age of sterilisation has come down across two decades but the parity instead of declining has increased and thus shows that with the decline in infant mortality, the fertility has not declined. Rather in 2005-2006 the average parity was 4.1 children. In view of above facts and central location of Jalalpur sub-centre, it is taken as the area of study. Thus, the universe of the present study is located in Jalalpur sub-centre of Lodha Block, Aligarh District in the state of UP, India. In the first stage of sampling the nodal village (where sub-centre is located) that is Ashrafpur Jalal and its adjoining village Alahdadpur Nivry are randomly selected as the units of study (see Map 4). It may also be noted that Ashrafpur Jalal has highest household size (that is 7 person) among the sub-centre villages followed by Alahdadpur Nivri (household size 6 person). Moreover, the sex ratio of Alahdadpur Nivri, in comparison to sex ration of Jalalpur sub-centre and Lodha block, is higher i.e. 896 and in case of child sex ratio it is 1030. The village Ashrafpur Jalal has high concentration of Hindus belonging to Lodha Rajput caste (OBC category) and Scheduled Castes (SCs). Alahdadapur Nivri village on the other has mixed population of Hindus and Muslims. The majority of Muslims here

belong to low caste[23] Alvi Syed (OBC category). In the second stage of sampling, the sample is drawn of contraceptive adopters. Noting the problem of reliable information about the temporary contraceptive adopters, it was decided to adopt sterilisation as the yardstick to define adopters and non-adopters.[24] To ensure comparability the equal sample of adopters and non-adopters is drawn and finally a sample size of 75 adopters and 75 non-adopters is fixed. Keeping in mind, the focus of study on personal and familial characteristics, it was decided to take only one respondent from a family or household. Thus, the sample is drawn from 150 households. Respondent in case of adopters means the currently married woman in the reproductive age group (15-49 years)[25] and has undergone sterilisation in last five years not later than that. In case of non-adopters, respondent means any currently married women in the reproductive age group (15-49 years) and has not undergone sterilisation, she may or may not be using any other temporary or traditional contraceptives. Initially, it was planned to select sterilisation cases

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[23] It may be noted that Islam is an egalitarian religion however in India it has come under the influence of endogenous caste system and thus Muslims in India do have caste categories. M.N. Srinivas rightly noted 'Islam proclaims the idea of equality of all those who prefers the faith, but in India it has been characterised by caste. Muslim caste differs in some respect from the Hindu caste system; there are no ethico-religious ideas justifying the hierarchy or regulating inter-caste relations through ideas of purity an pollution; there are no *varna* categories. What we have is a hierarchy formed by several *jatis*.' Mandelbaum citing from other sources also noted that 'Muslims in all regions of India class themselves into endogamous hereditary groups which are ranked in relation to each other.' The sociologists like Ghous Ansari and Imtiaz Ahmad have dwelled on this issue and categorised these into *Ashrafs, Azlafs and Arjals.* In this categorisation, the Muslims in the sampled area fall under the category of *Arjals.* See M.N. Srinivas, *India: Social Structure* (Delhi: Hindustan Publishing Corporation, 1982)., p. 7; Mandelbaum, *Society in India.*, p. 546; Ghaus Ansari, "Muslim Caste in Uttar Pradesh: A Study of Cultural Contact," *The Eastern Anthropologists* 13 (1960).; Imtiaz Ahmad, "Social Stratification among Muslims," *Economic and Political Weekly* 10 (1965).

[24] Thus, hereafter the adopters refer to sterilisation adopters and non-adopters refer to non-sterilisation adopters. In both categories there may or may not be ever-temporary contraceptive users.

[25] The age group 15-49 is taken because same is used in the calculation of Total Fertility Rate (TFR), which is defined 'the average number of children that would be born to a woman if she experiences the current fertility pattern throughout her reproductive span (15-49 years)'. See GOI, *Women and Men in India 2001.*, p. viii (Explanatory Notes).

from the Record Register of ANM using systemic random. It was soon realised that this list includes only all those cases that ANM of the area has taken for sterilisation, they may or may not be living in that area. Further, the list excludes sterilisation cases, which are done at private hospitals. Thus, it was decided to identify and select adopters with the help of key informants. In case of non-adopters the sample is randomly drawn excluding those households from where an adopter is selected for study. Thus, this sample of 150 households by way of inclusion-exclusion premise represents a wide cross section under the study.

2.3 Tools of data collection and analysis

A complete era of studies on fertility, family planning and contraceptive practice has witnessed use of interview-schedules or questionnaires[26] and today, so is the fervent against these structured techniques and quantitative studies. Rao even noted that an area of human behaviour as intimate as fertility behaviour cannot be understood by simply asking questions. Participant observation and case studies are helpful in providing access to this sensitive domain in human life. On similar lines, Caldwell *et. al*[27] highlight the unique contribution of participant observation and the strength of prolonged personal contacts with the fields. Very recently, Patel saw a strange coincidence that though village studies in India had their golden period

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[26] For example Rao review of 550 KAP studies on fertility, family planning and contraceptive practice during 1951-74 found that most studies had used interview-schedules or questionnaires with the exception of two that had used observation as a method. See Rao, *Studies in Family Planning: India.*

[27] J.C. Caldwell, P. Caldwell, and B. Caldwell, "Anthropology and Demography: The Mutual Reinforcement of Speculation and Research," *Current Anthropology* 28, no. 1 (1987).

roughly during the same period as demographic studies on fertility transition- from mid 1950s to mid 1970s- there was little communication between the two genres[28] and thus, she argued her research attempts 'a holistic perspective on fertility behaviour through monographic study of a village community'[29] to fill that gap. However, much earlier Djurfeldt and Lindberg[30] argued that dense descriptions of qualitative data support quantitative data. The present research is a modest attempt on similar lines.

The research study relies both on quantitative as well as qualitative techniques. To have more concrete facts survey method shall be used. For this purpose, pilot tested structured-interview schedule shall be used. The research shall also use a range of qualitative methodologies that includes case study, key informant interviews with related health workers/volunteers and focus group discussions (FGDs) with sampled respondents and more importantly 'informal discussions' with established old folks in the sampled villages. A total of ten key informants are chosen. They include ANM (Auxiliary Nurse Midwife) of the sub-centre under study, two AWWs (Anganwadi Workers), two ASHAs (Accredited Social Health Activists), three CMCs (Community Mobilisation Coordinators) and two young ladies (catalysts) with experiences of reproductive health (RH) activities in the sampled villages. The choice of each key informant is very rational and purposive, and is quite close to Vansina's[31]

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[28] Patel, *Fertility Behaviour.*, p. xxiv.

[29] Ibid., p. 1.

[30] G. Djurfeldt and S. Lindberg, *Pills against Poverty* (New Delhi: Oxford and IBH, 1976).

[31] Vansina noted a good key informant is one who still lives the customary life, who recalls traditional events and customs readily and enthusiastically, and who is old enough to have acquired some degree of personal experience of his cultural environment. See J. Vansina,

prescription. For example ANM is in the same area for the past twenty years and is unusually (of ANMs) very active, cooperative and hold command in her area. AWWs are well versed and are acting as resource person in reproductive health, one has even worked as community based distributor (CBD) in RCH (Reproductive and Child health) project. ASHAs are newly identified and trained health 'activist' on incentive basic under recently launched National Rural Health Mission (NRHM) of Government of India and thus were very enthusiastic and productive. CMCs though are polio volunteers of Unicef social mobilisation network but in the sampled villages, these chosen CMCs are work a team of health workers and have developed very clear understanding of RH issues and having motivated a number of female for sterilisation. The remaining two young ladies are having previous field experiences in health activities and are very confident and informative, so is reason I introduced them as catalyst. FGDs are planned because these reflect the views of the participants and in a way represent community attitudes. A total of ten FGDs of adopters and non-adopters together and separately, depending on the specific issue for discussions, are planned to crystallise the dynamics of contraceptive adoption and non-adoption. Similar is the rationale for the thirteen case studies of adopters and non-adopters. Many a times in between the research works/ field studies, one comes to know of people with reservoir of information on specific issues (which is usually not available), thus in present research space is provided to exploit the same by way of 'informal discussions'. Researcher's previous and prolonged exposure in the field somehow permits the use of these techniques, which otherwise might not

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Oral Tradition: A Study in Historical Methodology (London: Routledge and Kegan Paul, 1965).

be so friendly to a male outsider talking to females on most inmate and personal domain. The requisite secondary data on block profile sampled sub-centre shall be collected from block office, primary health centre and district hospital statistics section.

The data thus collected from a sample of one fifty households (75 sterilisation adopters and 75 non sterilisation adopters) shall be tabulated and analysed to test the hypotheses and draw inferences. The reliance is on simple and *sophisticated statistical techniques (percentages, mean averages and two tailed* t- test, hereafter, t- test), one for the researcher inability to 'handle' complex statistical tools and secondly due to the intension to support the quantitative data with dense qualitative data. The results and insights from FGDs, case studies, 'facts' from key informants and informal discussions, shall overcome the limitation of limited statistical use.

2.4 Operational terms

Personal and Familial characteristics

Personal characteristics here refer to the characteristics of sterilisation adopters and non-adopters women who are taken as sample of study and include their education, occupation and income. While the familial characteristics refer to the education, occupation and income of their spouses. The familial characteristics, in case of joint family, also include the similar traits of any one person (say father-in-law, mother-in-law, brother-in-law) who influence the major decisions in the family.

Family Welfare Programmes

The term 'family welfare programme' is a replacement to the term 'family planning programme' renounced by the Indian policy makers for 'self perceived goods'. To what extent the nomenclature change is beyond semantics and what it actually connotes has already been discussed. Desai made distinction between *family planning as self generating voluntary programme and family planning as a population control movement* [italics mine]'[32]. This distinction qualify the previously held connotation by Lappe and Collins who observed that the 'family planning as a valuable social service to facilitate individuals self determination and a legitimate way to increase people real options having the goal of providing every couple access to the tools necessary to choose the size of their family, is crucially different from 'Family Planning Programme' that purport to alleviate the problem of hunger by limiting population growth.'[33] To Raina the scope of family planning, however, is much wider than family limitation. 'Family planning is a scientific approach to deal with the problems of the family and contributing to the richness of life in family.'[34] On contrary to Davis 'family planning is a euphemism for contraception.'[35] Notwithstanding this, in present research the term family welfare programmes is restricted to 'dynamic process of contraception adoption, inter play of forces on discussion and decision to adopt contraceptives and consequences thereafter, if any.'

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[32] Desai, *Urban Family Planning in India.*, p. 136.

[33] Frances Moore Lappe and Joseph Collins, *Food First, Beyond Myth of Scarcity* (Boston: Houghton Mifflin Co., 1977)., p. 69.

[34] B.L. Raina, "Reseach in Family Planning," in *Studies in Demography- Essays Presented to Professor S. Chandrasekhar on His Fifty-First Birthday*, ed. Ashish Bose, P.B. Desai, and S.P. Jain (London: George Allen and Unwin, 1970)., p. 319.

[35] Davis, "Population Policy: Will Current Programs Succeed?.", p. 370.

Adopters and Non-adopters

Present research focus on the adoption of contraceptives. The difficulty arose from the fact that it is not easy to ensure that the respondent used contraceptives regularly.[36] Therefore, it is decided to accept adopters as those who have adopted terminal method of family planning i.e. female sterilisation. Thus, for the purpose of present research, adopters shall mean those women who have undergone sterilisation, and non-adopters as those who have not undergone sterilisation and that they may or may not be ever temporary or traditional contraceptive user. It may again be noted that sterilisation in the present research is restricted to female sterilisation.

[36] The same problem was also faced by Panandikar and Mehra and the present distinction is borrowed from their classification of acceptors and non acceptors. See Panandiker and Mehra, *People's Participation in Family Planning*., p. 20.

CHAPTER-3

PERSONAL AND FAMILIAL DETERMINANTS OF CONTRACEPTIVE ADOPTION IN RURAL MILIEU

CHAPTER-3

Personal and Familial Determinants of Contraceptive Adoption in Rural Milieu

It is reported that 'irrespective of urban jobs or the level of education, social expectations and values regarding sex and number of surviving children continue to dominate a couple's decision to stop or continue child bearing. The individual couple rarely decide their fertility career independent of social norms and compulsions from kin, neighbours, and the community. This is clear from the number of children born to educated and *naukri*-holding parent(s).'[1] The present research, as stated earlier, is restricted to a sample of 150 respondents with equal weight to sterilisation adopters (i.e. adopters) and non-sterilisation adopters (i.e. non-adopters) categories. This chapter (and subsequent chapters as well) explores the dynamics of sterilisation adoption or non-adoption ('event'/dependent variable) across major determinants ('properties' / 'conditions' or independent variables). This chapter specifically dwells on the question – how social correlates, and for that matter personal and familial characteristics *per se* influence the contraceptives adoption.

3.1 Socio-economic correlates of adopters and non-adopters

In fertility studies and those relating to adoption of family planning a whole genre of researchers have emphasized the determining role of socio-economic

[1] Patel, *Fertility Behaviour.*, p. 202.

correlates. In continuity with tradition, the present research analysis proceeds with a note on important socio-economic correlates that is religion, caste, family type, land holdings and political participation, and the extent to which they govern the process of contraceptive adoption.

Religion

The Indian population includes followers of six major religions: Hinduism, Islam, Christianity, Sikhism, Jainism, and Buddhism. These six religions account for almost 99.5 per cent of the total population of the country.[2] The NFHS[3] (read NFHS-1) data for 1992-93 show the Muslim TFR to be higher (4.4) than the TFR of Hindus (3.3) by 1.1 children. On the other hand, the IMR among Muslims (77) was about 14 per cent lower than among Hindus (90). However, to interpret these facts properly, Visaria and Visaria noted, 'it is important to remember that almost 36 per cent of the 101 million Muslims enumerated in 1991 lived in Uttar Pradesh and Bihar, the two states with the highest level of TFR'.[4] A good many of studies have dwelled on Muslims response to adoption of contraceptive methods. Panandiker and Mehra[5] in their analysis of people's participation in family planning noted that the

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[2] Visaria and Visaria, "India's Population.", p. 74.

[3] International Institute for Population Sciences., *National Family Health Survey (Mch and Family Planning) India, 1992-93.*, pp. 214-15.

[4] Visaria and Visaria, "India's Population.", p. 74. It can also be noted that these states are persistently poor in vital demographic indices, a reason why Ashish Bose putted them in the category of BIMARU states and more recently, argued that their condition is still poor enough to remain in the same category. See Bose, *From Population to People.*, Bose, *Beyond Demography- Dialogue with People.*

[5] Panandiker and Mehra, *People's Participation in Family Planning.*, p. 29. This study was based on a sample of 220 acceptors of sterilisation and 110 non-acceptors. The sample was drawn from two models, that is, of voluntary organisations (four voluntary organisation from Delhi, Gujarat and Maharastra) and Panchayati Raj Institutions (PRIs) from Madhya Pradesh and Gujrat.

extension workers did not encounter any organised religious opposition to the programme in Delhi. Infact, one of the most successful cases was that of Muslim-majority villages near Okhla. Khan in his study on Muslims of Kanpur noted that majority of the (83.9 per cent males and 64.5 per cent females) respondents were in favour of family planning.[6] He also observed that the majority of them were either moderately or very positively in favour of family planning. Those who were against it were totally against the idea of contraception. A very few were either neutral or moderately against family planning. Further, of the total sample, just 50 per cent had used contraceptives at one time or another.[7] Khan also compared the results with the contemporary fertility survey in Lucknow city and observed that 'the percentage of the 'ever users' in the present study is larger than the 'ever users' of all castes and religious groups in the Lucknow survey.'[8] In the Lucknow study[9], 46 per cent of the Christians, 45 per cent of the upper caste Hindus, 20 per cent of the Sikhs and 17 per cent of the Muslims had ever used any contraceptive. The percentage of the 'ever users' among the lower or middle caste Hindus was below (7 to 8 per cent) the average (31.5 per cent).

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[6] Khan, *Family Planning among Muslims in India.*, pp. 149-150.

[7] Ibid., p. 160.

[8] Ibid., p. 162. Khan further notes that this study contradicts the general belief that Muslims do not accept family planning and fanatics propaganda that if the Hindus adopt the recommended norms of two or three children per couple, they will be reduced to minority by 2051 A.D. and that the Muslims and other non Hindus will become a majority (Hendre, 1971) . This study supports the several other studies (Pethe; P.E.O.) that have shown that such a suspicion is baseless and that it is factual wrong to say that Muslims are not adopting family planning. See Sudhir Hendre, *Hindus and Family Planning* (Bombay: Supraja Prakashan, 1971)., p. 35; Vasant P. Pethe, "Hindu, Muslim and Demographic Balance in India," *Economic and Political Weekly* (1973)., Planning Commission, "Family Planning Programme in India: An Evaluation," (New Delhi: Programme Evaluation Organisation, Planning Commission , GOI, 1970).

[9] D.N. Saksena, "Differential Urban Fertility in Lucknow," (Lucknow: Demographic Research Centre, 1973).

The table 3.1.1 presents the religion-wise break-up of the sampled population in Jalalpur sub-centre, Lodha Block Aligarh (UP). It shows that of the total sample, 69 per cent (104) are Hindus and 31 per cent (46) are Muslims. The cross-table also reftects that in the adopters' category 67 per cent (50) are Hindus while 33 per cent (25) are Muslims, and in case of non-adopters, the Hindus are 72 per cent (54) and Muslims are 28 per cent (21). Thus, the table does not present a clear picture of sterilisation adoption across religions.

Table 3.1.1: Distribution of Adopters and Non Adopters across the Religion

Religion	Sterilisation status		Total
	Adopters	Non Adopters	
Hindus	50 (67%)	54 (72%)	104 (69%)
Muslims	25 (33%)	21 (28%)	46 (31%)
Total	75 (100%)	75 (100%)	150 (100%)

Source: Survey data

The picture somehow becomes clear if we tabulate adopters and non-adopters together with individual religious groups (i.e. across the rows). In this case among the total Hindus (104) in the sample, 48 per cent (50) are adopters while among the Muslims out of the total (46), the adopters are 54 per cent (25). Further, within each religious category, if we look for ever temporary contraceptive usage among adopters and non-adopters together (table 3.1.1.1), then among Hindus, the ever temporary contraceptive users slightly declines (in comparison to Hindu sterilisation adopters) to 43 per cent (45) while in case of Muslims, the same slightly increases (in comparison to Muslim sterilisation adopters) to 59 per cent.

However, given sample size, it will be too much to generalize that religion is not significant variable in sterilisation adoption, and that Muslims as group

have higher affinity to temporary contraceptives (in comparison to sterilisation) than Hindus whose percentage in the adoption of temporary contraceptives (in comparison to sterilisation) declines. Thus, instead of finding answers in decimals, lets see how the sample population of Hindus and Muslims, adopters and non-adopters themselves relate religion with the contraception.

Table 3.1.1.1: Distribution of Ever Temporary Contraceptive Users (Adopters and Non Adopters) across the Religion

Temporary Contraceptive usage	Religion		Total
	Hindus	Muslims	
Ever users	45 (43%)	27 (59%)	72 (48%)
Never users	59 (57%)	19 (41%)	78 (52%)
Total	104 (100%)	46 (100%)	150 (100%)

Source: Survey data

For this purpose, focus group discussions (FGDs) were organised separately with each religious group. Each group consisted of a total 10 women in the age group 25-40 years. However, both FGDs with Hindus (refer **FGD-1**), and with Muslims (refer **FGD-2**) dwelled around same theme of understanding the religious 'world view' of sampled population in regard to contraception. The discussions in both the groups proceeded systematically around the following issues– perception about children, need of birth control, and if any, the permissible methods of birth control. Further, in both the FGDs researcher was key facilitator, supported by other facilitators namely Auxiliary Nurse Midwife (ANM) and Accredited Social Health Activist (ASHA), both of them proved to be the main icebreakers. In FGD-1 there were 10 women in the age group of 25-40 years and out of these 4 were adopters and 6 were non-adopters. The group in process was also joined/disturbed by an old lady (60

years plus) who was bold enough to comment on the issue harshly and thereafter leave away the group. Her brief 'observations' were worth important to be incorporated. In FGD-2 also there were 10 women in the same age group as of FGD-1 (i.e. 25-40 years) and out of these 3 were adopters and 7 were non-adopters. Another old lady (70 years plus) at later stage joined this group also. She made the discussion lively till the end. Her experiences were vast enough to be taken into cognisance. However, researcher (as a key facilitator) remained also attentive enough to avoid group polarization. The researcher summarised the discussions in both FGDs and accordingly draw inferences and presented the same to both groups to ensure their group acceptance.

It came out from FGDs that to both groups children are worth important to continue generations (*khāndān/kul*), and support family and parents; and for the same reasons God (*Allah/Bhagwan*) bless them with children. Children are God's blessings to parents (nēmat/dēn). Further, all did consider their inability to afford large number of children and thus necessity to restrict children after a maximum of 3-4 children. However, members within both the groups differed and debated on the issue of how to control childbirth. Some prescribed 'self control as best control', others commented on its impracticality. One young lady in Muslim group even said, 'it is sin to refuse husband (for coitus)' (*hamārē yahan 'manā' karnā gunah hai*). The groups were then facilitated towards discussion on temporary contraceptive methods. Among Muslims, younger age groups (less than 30 years) were quite ignorant about modern temporary contraceptives in comparison to Hindus. However, in both groups

most known temporary methods were Oral Contraceptive Pills (OCPs or simply pills called locally as *goli*) and Condoms (*nirodh)*. Both groups showed no religious constraints or inhibitions in the use of temporary methods but all those who used these argued for their unreliability and side effects. However, the discussions heated up, between both groups, on the issue of sterilisation. In FGD-1, all the Hindu women, including sterilisation adopters, were reluctant in giving outright support for sterilisation. They related sterilisation to becoming 'infertile' – which is considered as 'biggest curse to a women'. Thus, those who have undergone sterilisation argued that they have done the same 'due to of extreme necessity' (*majbūrī mein karwāya*) and expect 'pardon from God' (*bhagwan māf kare*). Another lady, a non-adopter, narrated that God punishes the sterilised women by taking away 'a living child' (*jindā bachchā mar jātā hai*) and even said she has seen many such incidents. In between the discussion came the said old lady (60 year plus) and addressing to sterilised women, she lambasted that 'they are now neither male nor female' (*kat ke na admi mein na aurat mein*) and then more boldly addressed us to be responsible for this 'sin' and hence are sinner (*ye log pāpi hain*) and before anything more she left without replying our humble wish '*namastē*' (which is a norm to answer in rural Indian traditions). Likewise in FGD-2 there was also divergence. Further, among adopters both the senior and younger age group ladies argued that 'it is against religion' (*manā hai*). The old lady (70 years plus) much prevailed here and became much critical, harsh and vocal as soon as question of sterilisation surfaced. She even warned that 'had you (researcher) been not from our community (Muslim) and university (AMU, towards which they have respect) we would have thrown you out and even not

asked to sit here.' But in so quick a manner, was she pacified also to narrate her valuable experiences. She again cited (like in FGD-1) examples of sterilised women experiencing death of living children as post-sterilisation punishment, wrath of God (*khudāi mār*). Furthermore, the adopters lamented of their compulsion to go for the same. Some argued for confusion over the issue- God knows what is right (*Allah Janatā hai sahi kyā*). But one young lady, a non-adopter forcefully argued that 'even the women from the families of religious leaders are going for sterilisation, why can't we? What else to do? Have children and make them beggar? (*mullon ke ghar se karāne ja rahī hain – hum kyon nahī. Phir kya karen – bachche paidā karein aur bhīkh mangvayen*). One lady educated up to primary level, very brilliantly related the issue to drugs and argued like drugs are permitted to take for illness, though they contain alcohol, which is prohibited in Islam (*harām*) so is the case of sterilisation (locally called as *aprēsan*) which is taken as last resort to restrict the birth of more children, who are unaffordable to family and the burden has to bore by women. With these hot discussions in both groups, the members agreed with researcher summary that sterilisation *per se* is not something one longed for, but is and can be undertaken in the event of necessity like when children are unaffordable. On this note both groups agreed. It may also be mentioned that in process of long discussions in both FGD-1 and FGD-2 members requested and latter on listened to 'right use of temporary contraceptives' and sought classifications regarding myths attached to temporary contraceptives. The most common were Intra-Uterine Contraceptive Device (IUCD/IUD/ Cu-T) moving up in body and pills (*goli)*

producing *garmī* (heat) in body. The researcher[10] and ANM warmly clarified the same. Muslim women particularly lamented for the non-availability of temporary contraceptives (which they needed most) and some even asked us to facilitate other women in community who want to go for sterilisation, which we warmly reciprocate.

It is clear from the FGDs (FGD-1 and FGD-2) that women in Hindu or Muslim groups are conscious, clear and quite rational in terms of their religious, cultural or community notions on the one hand and their dire necessities on the other. It is also clear that in most groups there is high unmet need for temporary contraceptives (towards which there are no religious inhibitions). They are even ready for sterilisation, if circumstances warrant so. This point is worth important from policy and programme interventions perspective. Thus there is an urgent need of facilitating the easy availability of temporary contraceptives and counselling for their correct and consistent use to make contraceptive usage effective. This will truly have bearing on fertility rate (towards replenishment level) rather than simple increasing the contraceptive prevalence rate (CPR)!

Caste

The caste system is a unique feature of the Indian social structure. 'The institution of caste provides a common cultural idiom to Indians: wherever one

[10] Researcher is recently given *Certificate of Competence in RH (Reproductive Health) Training* by Pathfinder International, New Delhi and thus it was pleasure to have more in-depth understanding of the subjects by way of their counselling and clarifications.

may be in India one is in a universe of caste.'[11] In the study of any kind of social behaviour, it is desirable that caste should be taken as an independent variable and its influence be understood properly.[12] It has been observed in several studies[13] (for example Mysore study, Chandrasekharan and George, Rele, Wyron and Gordon, and Saksena), that the higher caste couples had relatively lower fertility than those of low caste couples. Mamdani further noted that caste and occupational structure of the village are the important determinants of the villager's perceptions of the costs and benefits of children.[14] Visaria and Visaria[15] have pondered over the contraceptive use among Scheduled Castes (SCs) and Scheduled Tribes (STs) and argued that the relative poverty of the SC/ST population is presumed to make them suffer from higher than average levels of mortality and morbidity. This is supposed to be compensated for by a higher fertility because of a lower age at marriage as well as the lesser prevalence of the use of contraception. They quoted NFHS data of 1992-93, which confirmed that total fertility was highest among the SCs, followed by the STs and the other non-scheduled castes population; but the difference between the highest and the lowest values was only about 19 per cent. Contraceptive use among the SCs and STs was of the order of 33-

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[11] Quoted by Mandelbaum who further agued that studies done in all parts of the land confirm this statement of Srinivas. See Mandelbaum, *Society in India.*, p. 228.

[12] Khan, *Family Planning among Muslims in India.*, p. 8.

[13] U.N., "The Mysore Population Study.", C. Chandrasekaran and M.V. George, "Mechanisms Underlying the Differences in Fertility Patterns of Bengalee Women from Three Socio-Economic Groups," *Milbank Memorial Fund Quartely* 40 (1962)., J.R. Rele, "Fertility Differential in India," *Milbank Memorial Fund Quartely* 41 (1963)., Wyon and Gordon, *The Khanna Study : Population Problems in the Rural Punjab.*, Mamdani, *The Myth of Population Control : Family, Caste, and Class in an Indian Village,* Saksena, "Differential Urban Fertility in Lucknow."

[14] Mamdani, *The Myth of Population Control : Family, Caste, and Class in an Indian Village.*

[15] Visaria and Visaria, "India's Population.", p. 73; International Institute for Population Sciences., *National Family Health Survey (Mch and Family Planning) India, 1992-93.*, p. 97, 148.

4 per cent, about 21 per cent lower than among the 'other' population (42 per cent). However, it is noted that these studies correlate fertility with specific caste groups without taking into account the structural conditions and social norms within a caste influencing fertility behaviour.[16] Patel in her Rajasthan study further observed that 'the mean number of children born in various caste categories thus does not vary largely among them, and from the overall village mean of 4.94' and concluded that 'there is no linear correlation between caste and fertility'.[17]

Our sample (from Jalalpur sub-centre) shows that 16 per cent are from general caste category, 41 per cent are from scheduled caste category (SCs) while those from Other Backward Classes (OBCs) are 43 per cent (table 3.1.2).

Table 3.1.2: Distribution of Adopters and Non Adopters across the Caste category

Caste category	Sterilisation status		Total
	Adopters	Non Adopters	
General	17 (23%)	7 (9%)	24 (16%)
SC	33 (44%)	28 (37%)	61 (41%)
OBC	25 (33%)	40 (53%)	65 (43%)
Total	75 (100%)	75 (100%)[18]	150 (100%)

Source: Survey data

[16] Patel, *Fertility Behaviour.*, p. 68. Patel further supports her argument by quoting Kolenda, and Conklin who observed that such correlations rarely reveal any significant association. See P. Kolenda, "Region, Caste and Family Structure: A Comparative Study of the Indian Joint Family," in *Structure and Change in Indian Society*, ed. M. Singer and B.S. Cohn (New York: Wenner-Gren Foundation for Anthropological Research, 1968)., G.H. Conklin, "Family Structure, Caste and Economic Development- Rural Comparison from Dharwar," in *Family and Social Change in Modern India*, ed. G.R. Gupta (Delhi: Vikas, 1976).

[17] Patel, *Fertility Behaviour.*, p. 67.

[18] The per centage totals with superscript * here and afterwards in this thesis show a variation of ± 1 (i.e. 99 or 101 instead of total 100) owing to repeated numbers after decimal points and the rounding off of the same.

It also shows distribution of adopters and non-adopters across caste categories. Among adopters 23 per cent belongs to general category, 44 per cent to SCs and 33 per cent to OBCs. In the case of non-adopters, 37 per cent are SCs and 53 per cent are OBCs, while in the general category non-adopters are 9 per cent. Thus in the study area the percentage of sterilisation adoption among SCs is quite higher than general category (almost 20 points) and also from OBCs (10 points). Further in case of adoption the t-test also shows significant relationship across caste categories (t= 5.413; P= .032). The table 3.1.2.1 presents the distribution of ever-temporary contraceptive users across individual caste categories. It shows that in general category only 40 per cent are ever temporary contraceptive users while among SCs and OBCs the percentages are 43 per cent and 53 per cent respectively.

Table 3.1.2.1: Distribution of Ever Temporary Contraceptive Users (Adopters and Non Adopters) across the Caste category

Temporary Contraceptive usage	Caste Category			Total
	General	SC	OBC	
Ever users	10 (42%)	26 (43%)	36 (55%)	72 (48%)
Never users	14 (58%)	35 (57%)	29 (45%)	78 (52%)
Total	24 (100%)	61 (100%)	65 (100%)	150 (100%)

Source: Survey data

A comparison of table 3.1.2 and 3.1.2.1 shows that among SCs themselves caste category the relative percentage of ever-temporary contraceptive usage (43 per cent) is almost same as in case of sterilisation adoption (44 per cent). However, the matrix changes in the general and OBCs categories. In general category percentage of ever-temporary contraceptive users increased to 42 per cent (table 3.1.2.1), which is quite significant in comparison to 23 per cent adopters in the same category (table 3.1.2). Similarly, ever-temporary

contraceptive users among OBCs also increased to 55 per cent in comparison to 33 per cent sterilisation adopters in the same caste category. Thus in case of temporary contraceptives the variations between general category and SCs is minimal although OBCs are more than 10 points ahead of two in the case of temporary contraceptive adoption. Here it is also pertinent to be noted that these inferences should be read in the light of the fact that OBCs here includes both Hindu and Muslim OBCs. And also that Hindu OBCs in Lodha block belong to Rajput Lodha Caste, which is a land owning casts in this region. Further, SCs are only among Hindus, while general represents Hindu higher castes and Muslims upper strata.

Family Type

Kingsley Davis[19] looking for institutional pattern favouring fertility argued that in the extended family the burden of marriage and of child bearing does not fall upon the parents, but upon the entire family and is so diffused that the burden to any one person may be seen as relatively light. Further, the presence of numerous relatives means that the wife is not particularly burdened with the care of the young children. Poffenberger[20] has noted that the retention of traditional values and comparative lack of husband-wife communication in a joint family are also factors that may favourably influence fertility. Nag Moni[21] on contrary argued that a nuclear family also may lead to an increase

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[19] Kingsley Davis, "Institutional Pattern Favouring High Fertility in Underdevelped Areas," *Eugenics Quarterly* 2, no. 1 (1955).

[20] T. Poffenberger, *Husband-Wife Communication and Motivational Aspects of Population Control in an Indian Village* (New Delhi: Central Family Planning Institute Monograph Series, No. 10, 1969).

[21] Moni Nag, "Family, Type and Fertility" (paper presented at the World Population Conference, Belgrade, 1965).

in the number of children because of greater privacy and greater chance of sexual activity. While Mishra[22] argues that it (nuclear family) may reduce the fertility also by increasing husband and wife communication and empathy. On other extreme Mathen[23] in his Singur study found no significant difference between the family size of couple living in single families and those living in joint families. More recently, Patel[24] also find hardly a significant difference in fertility in simple and complex households. Khan[25] in the light of his Kanpur study crystallised the subtle issues inherent in explaining the relationship between fertility and family type and observed that it is interesting to note that the fertility of the nuclear family in its early stage (duration of marriage zero to nine years) is quite high as compared to the corresponding figure for joint family. The difference in fertility is negligible for females with ten to thirteen years of married life and just reverses for female married twelve or more years before the survey. This may be because in a nuclear family couples get more privacy. Young couple in a joint family get fewer opportunities to mix together due to both shyness and lack of space. As the duration of marriage increases, the shyness gradually decreases and the

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[22] B. D. Mishra, "A Comparison of Husbands and Wives Attitude Towards Family Planning," *The Journal of Family Welfare* XII, no. 4 (1966).

[23] K.K. Mathen, "Preliminary Lessions Learned from the Rural Population Control Study of Singur," in *Research in Family Planning*, ed. C.V. Kiser (Princeton: Princeton University Press, 1962).

[24] Patel, *Fertility Behaviour.*, p. 64. Patel has also strongly emphasized on futile exercise of correlating family type with fertility without taking into account the development process of household. She noted 'at one time a household may be simple, complex, or a variation thereof. If the development process of the household is disregarded, then it would seem that the children of a couple were all born in one household type. The analysis will not convey how many children were born before and after the change in the household structure (type).' See Patel, *Fertility Behaviour.*, pp. 65-66., on development process of household see M. Fortes, "Introduction," in *The Development Cycle of the Domestic Groups*, ed. J. Goody (Cambridge: Cambridge University Press, 1958)., A.M. Shah, *The Household Dimension of the Family in India* (Delhi: Orient Longman, 1973)., J.W. Ryder, "Interrelations between Family Structure and Fertility in Yucatan," in *Anthropological Studies of Human Fertility*, ed. B.A. Kaplan (Michigan: Wayne State University Press, 1976).

[25] Khan, *Family Planning among Muslims in India.*, pp. 71-72.

reduced rearing cost of children resulting from mutual cooperation and assistance among the family members may cause higher fertility. In contrast to the joint family, in the nuclear family as the number of children increases, the economic responsibility of the parents also increases. Here the father alone has to bear the economic burden thus he may decide to control the number of children.'

In the present research the adopters and non-adopters are cross tabulated across the family type. The nuclear or joint typology is used simply to see variations in personal and familial dynamics in contraceptive adoption. Thus in a nuclear family the focus is on husband and wife both and how they individually and as a family affects the process of contraceptive adoption. In the same stream, the joint family represents husband, wife and at least one significant other (i.e. mother-in-law (*sās*), father-in-law (*sasur*) or elder brother-in-law (*jyeth*) who matters in family decisions making). Thus, nuclear and joint categories only represent the variation in dynamics of communication and power relation in contraceptive adoption. Table 3.1.3 shows that in the total sample, 75 per cent are nuclear families and remaining 25 per cent are joint families. This again reflects the increasing peri-urban nature of Lodha block which surrounds Aligarh city from three sides, in general and Jalalpur sub-centre in particular where the city has penetrated and impact is apparent outwardly. The table also informs that among adopters 76 per cent are from nuclear family while 24 per cent are from joint families. Similarly among non-adopters, the percentage of those belonging to nuclear family is 73 and of those in joint are 27 per cent. Thus the given sample does

not present the clear picture across family types. Looking at table 3.1.3 horizontally, i.e. across rows one finds that of the total respondents in nuclear family type, 51 per cent are adopters while of that total in joint families, the percentage of adopters is 47 per cent. Thus, within each family type the percentage of adopters is more in nuclear family than in joint family.

Table 3.1.3: Distribution of Adopters and Non Adopters across the Family type

Family type	Sterilisation status		Total
	Adopters	Non Adopters	
Nuclear family	57 ((76%)	55 (73%)	112 (75%)
Joint family	18 (24%)	20 (27%)	38 (25%)
Total	75 (100%)	75 (100%)	150 (100%)

Source: Survey data

Similarly, in respect to ever temporary contraceptive usage, the percentage of ever users is 48 per cent in nuclear families while it is 47 per cent in joint families (table 3.1.3.1). Thus, the family typology (nuclear /joint) in the sample is insignificant in case of ever-temporary contraceptive usage and in case of sterilisation; nuclear families have an edge over the joint families. However, the inference needs more qualitative inputs.

Table 3.1.3.1: Distribution of Ever Temporary Contraceptive Users (Adopters and Non Adopters) across the Family type

Temporary Contraceptive usage	Family Type		Total
	Nuclear	Joint	
Ever users	54 (48%)	18 (47%)	72 (48%)
Never users	58 (52%)	20 (53%)	78 (52%)
Total	112 (100%)	38 (100%)	150 (100%)

Source: Survey data

On the question- do family type matters in the contraceptive adoption? If yes, how? We can attempt more qualitative answer in the case study (refer **CSN-1**). Guddo, a Muslim lady aged 30 years having 5 children (3 sons and 2 daughters) against a total of 8 pregnancies and has undergone sterilisation at

the age of 28 years. Presently, she is working as a volunteer (health) in govt. programmes like polio eradication, DOT (Tuberculosis) programmes and also liaison with ANM to provide sterilisation cases, who towards the end of year needs sterilisation cases to fulfil her prescribed 'target'. Guddo answers the above questions from her own experiences and those of other sterilisation adopters in her community. In her opinion and experiences, family type matters a lot especially in case of sterilisation adoption. She argued that in nuclear families normally husband and wife come to agreement looking over the number of children and poor family conditions, and even in course of disagreement wife can attempt unilateral decision to undergo sterilisation, after which husband is left with nothing but to pacify himself as is evident from responses like to say 'whatever happens is good' (*jo hua achchhā huya*). However, in the case of joint family, particularly, if both father-in-law and mother-in-law are alive, the process of sterilisation is bit complicated. It is very difficult for the poor women to secure support of mother-in-law and through her of family patriarch. Usually, husbands, even if in agreement, do not talk to their elders on this issue. Guddo is of opinion that in joint families either permission is not granted or it takes such a long time that one ends with another child, so was her case. Further in joint families, women cannot dare to take extreme step of understanding sterilisation until and unless, husband's implicit consent is there. However, in the case of temporary usage there is no much difference, and the data in table 3.1.3.1 so reflect.

Land holdings and political participation

The question of landownership remains an important variable defining fertility. Visaria and Visaria observed that the average size of household rose with a rise in the size of the landholding possessed by a household, from 3.9 for the landless and 6.2 for households with more than 4 hectares (ha) of land.[26] However, Driver in Central India, Mamdani in Punjab and Patel in Rajasthan did not find any linear correlation between fertility and land ownership.[27] For example, Mamdani noted everyone wanting more children irrespective of land ownership in Khanna villages in Punjab. Many scholars have noted that the struggle for precedence and dominance are endemic in village India and that there is competition for status and power between people within the village.[28] These notions have also bearing on the fertility behaviour for example, both the studies of Khanna villages reported on people's perception that bitter faction fights in villages are won by men, not contraceptives.[29] Patel observed 'I wish to say that having several children, especially sons, is a sure protection for parents against denigration and deprivations. This does not mean that couples have children with the primary and explicit purpose of deriving political advantage.'[30]

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[26] Visaria and Visaria, "India's Population.", p. 76.

[27] Edwin D. Driver, *Differential Fertility in India* (Princeton: Princeton University Press, 1963)., Mamdani, *The Myth of Population Control : Family, Caste, and Class in an Indian Village*., Patel, *Fertility Behaviour*.

[28] F.G. Bailey, *Caste and the Economic Frontier* (Manchester: Manchester University Press, 1957)., O. Lewis, *Village Life in North India* (Urbana: University of Illinois Press, 1958)., M.N. Srinivas, "The Dominant Caste in Rampura," *American Anthropologist* 61 (1959)., Mandelbaum, *Society in India*.

[29] Wyon and Gordon, *The Khanna Study : Population Problems in the Rural Punjab*., Mamdani, *The Myth of Population Control : Family, Caste, and Class in an Indian Village*.

[30] Patel. *Fertility Behaviour*., p. 98.

It may be noted here that in the sampled population the land holding aggregate is much less. For example only 13 per cent (10) of adopters are having their own agricultural land and out of these, majority i.e. 80 per cent (8) has 2 or less *bigas*[31] of land, remaining two have 8 *bigas* and 50 *bigas* of land holding. Thus, those involve in agriculture and allied works are either land less labourers or working on leased land or on their own plus leashed land. Although among non-adopters also per centage of landholders is almost same 15 per cent (11) but within them 45 per cent have 2 or less *bigas* of land rest have more ranging from 5-10 *bigas* with 3 non-adopters to 20, 25 and 109 *bigas* of land with one each non-adopter. The following case studies further crystallised the issue. Satyawati (refer **CSN-2**) aged 30 has undergone sterilisation at the age of 28 years with 5 children (four sons and one daughter) against seven pregnancies. Her is a joint family with land holding of 50 *bigas*. This joint family only consisted of 8 members i.e. both Couples, their 5 children and father-in-law. Satyawati is illiterate but works as a health volunteer and earns a monthly sum of Rs. 500 while her husband remains idle and do not work. Satyawati's father-in-law carries agricultural activities to supplement the family income. Satyawati argues that with 5 children and puzzled of husband idleness, she went for sterilisation with indirect consent of father-in-law, and even unwillingness of husband. Thus, here economic burden of responsibility falls on significant other (father-in-law) and probably due to same reason he consented and supported her daughter-in-law against idle son wishes. Lets look for another case study from no-adopters but landed

[31] *Biga* is a local land measurement unit and varies from region to region. In Aligarh one acre is equal to five *bigas* and in terms of more standard unit hectare there are 12 *bigas* in one hectare.

class. Rajwati (refer **CSN-3**) aged 38 years is non-adopter (and also never contraceptive user) has 2 children both males (against 2 pregnancies). She lives in a joint family, which consists of 12 members, and the family's total land acreage is 109 *bigas*. Her husband is intermediate educated and is a government servant. The head of family is mother-in-law who is also educated upto X standard. Father-in-law mainly looks after agriculture, while her other children are also in service. Rajwati and her family both favour small family of two children (one male and one female) and according to her, children are born late and last child was born at age of 25 so there is no chance of any more child birth and hence she has not used any contraceptives.

The data in table 3.2.2 and the case studies illustrate that skilled work or service put women under duress owing to scheduled hours of work and back home caring of children and family. In the sample population women in the category of service/skilled work are employed in the lock factories in Aligarh city and daily they walk more than 5 km one way (10km to and fro) and that's why to them any child after 3-4 is least desirable. Thus, outside paid employment of women coupled with service/business occupation of spouse have cumulative effect to favour less children and have sterilisation even if the family has substantial land acreage.

The poor land holding pattern of sampled population is poor so is the case of political participation. Out of the total sample, only 9 per cent (13 out 150) has a family history in politics that also at village level. Out of these, 11 are among adopters and 2 are non-adopters. It may be noted that this participation is not out of long familial political background but the reservation

opportunities provided to women, SCs and OBCs at *panchayat* level by the 73rd Amendment of the Indian Constitution which provides for reservation across the levels and categories (Article 340-D of the Indian Constitution). However, the political participation is rather encouraging them and exposing them to positive outlook and a quality life. For example, Suchita (refer **CSN-4**) aged 35 is a non-adopters with three (one son and two daughters) children (no pregnancy waste). Her father-in-law has been elected *gram pradhan* and family owns 25 *bigas* of land. Further her husband is a graduate and do service. Suchita is a temporary contraceptive user and maintain the spacing by using of Condoms. For example, her last birth was at the age of 26 years. She said both of us are educated and are capable to correctly use temporary methods (i.e. condom) and hence no need for sterilisation. Further, she argued that her father-in-law keep prodding (indirectly) them for small family and good upbringing of children. He keeps on citing examples of government administrators having small families.

3.2 Personal and familial characteristics of adopters and non-adopters

Education

It is rightly observed that primary education and literacy is one such a vital sector which cannot brook any more neglect, even in the matter of achieving the small family norm.[32] Husain's study[33] of Lucknow city showed a steady decline in the general fertility rate with increasing female education even from

[32] Mitra, "The Small Family Norm and Literacy.", p. 300.

[33] I.Z. Husain, "An Urban Fertility Field: A Report on City of Lucknow," (Lucknow: Demographic Research Centre, 1970)., I.Z. Husain, "Educational Status and Differential Fertility in India," *Social Biology* 17 (1970).

among the illiterate (163.89) to next category below primary (145.16) and through primary (102.04), secondary (96.20) and higher (63.38). Mason[34] has commented on women education and contraceptive correlates that improvement in the status of women achieved through education increases their access to other value systems and also improves women's knowledge, attitudes and practice of family planning. Similarly, Caldwell and others[35] report from their investigation of demographic change in rural Karnataka that husbands treated wives who had been to school differently and listened to them more closely than husband whose wives had not been to school. More recently, Chaudhury[36] macro level study of inter state variations also confirms a positive relationship between female education and the use of contraception. The propensity to use contraception in a state rises sharply with increase in the literacy rate of that state. ....It appears that the formal education of girls (for a minimum of 1-4 years) could help India go a long way towards achieving a major breakthrough in the use of contraception and in lowering fertility.' However, some studies negate the impact of education *per se* on fertility reduction. It was observed in Mysore study[37] that education below high school had no significant relation with fertility. Driver's survey[38] in Nagpur district

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[34] K. Oppenheim Mason, "The Status of Women: A Review of Its Relationships to Fertility and Mortality," in *Paper presented for the Population Sciences Division of the Rockfeller Foundation* (1984).

[35] J.C. Caldwell, P.H. reddy, and P. Caldwell, *The Causes of Demographic Change: Experimental Research in South India* (Madison: University of Wisconsin Press, 1988). Much before Mysore Study revealed that in Bangalore city the average number of children born to ever-married illiterate women above the age of 45 was about 5.4, while that for women with high school or college education was 3.9. See U.N., "The Mysore Population Study.", cited in Raina, "Reseach in Family Planning.", p. 310.

[36] Chaudhury, "Factors Affecting Variations in Fertility by States of India: A Preliminary Investigation.", p. 68.

[37] U.N., "The Mysore Population Study."

[38] Driver, *Differential Fertility in India.*

(Maharastra) also indicated a similar relationship between women's education and fertility. Khan[39] in his Kanpur study (UP) also noted that the education of husband and wife showed an unexpected but weak negative association with family planning practice, and the reason for this was not clear even to him. Similarly, Patel[40] argued that there is an inverse correlation between education and fertility in Mogra (Rajasthan). More recently, Parikh and Gupta[41] argue that the surveys since the late 1970s have sought to explore female literacy and its role in the reduction of fertility. The data available, however, have not been used for a multiple regression analysis of the relationship. They on the one hand quoted from the volume by Jeffery and Basu[42] which contains number of article summarising evidences from micro level studies from different parts of India and South Asia, and on the other, analysed the data from National Family Health Survey, 1992-93 and concluded that 'female literacy reduces birth rates in Andhra Pradesh and Uttar Pradesh. However, the reductions are surprisingly small in percentage terms. Thus, female literacy even when we account for its impact on the age of marriage and cohabitation is not the magic bullet for population control that it is often thought to be...Female literacy is a critical preconditioning for women's development and must be encouraged. Yet, without overall development, don't expect miraculous reductions in fertility just from it.'

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[39] Khan, *Family Planning among Muslims in India.*, p. 168.

[40] Patel, *Fertility Behaviour.*, p. 63.

[41] Kirit S. Parikh and Chiranjib Gupta, "How Effective Is Female Literacy in Reducing Fertility?," *Economic and Political Weekly* XXXVI, no. 35 (2001)., pp. 3391-3392, 3397-3398.

[42] Roger Jeffery and Alaka M. Basu, eds., *Girl's Schooling, Women's Autonomy and Fertility Change in South Asia* (New Delhi: Sage Publications, 1996).

Thus the level of literacy has been much acknowledged, credited as well as discredited for cumulative effect on fertility and family planning. In the present study personal and familial educational status of adopters and non-adopters have been cross-tabulated and presented in table 3.2.1.

Table 3.2.1: Personal and Familial Educational status of Adopters and Non Adopters

Educational status	Sterilisation status							
	Adopters				Non Adopters			
	Personal	Familial			Personal	Familial		
	Self	Husband	Significant Other	Total	Self	Husband	Significant Other	Total
Illiterate	55 (73%)	25 (33%)	9 (50%)	89 (53%)	48 (64%)	24 (32%)	11 (55%)	83 (49%
I-V	8 (11%)	13 (17%)	3 (17%)	24 (14%)	15 (20%)	15 (20%)	4 (20%)	34 (20%
VI-X	11 (15%)	28 (37%)	3 (17%)	42 (25%)	7 (9%)	21 (28%)	2 (10%)	30 (18%
Above X	1 (1%)	9 (12%)	3 (17%)	13 (8%)	5 (7%)	15 (20%)	3 (15%)	23 (14%
Total	75 (100%)	75(100%)	18 (100%)	168 (100%)	75 (100%)	75 (100%)	20 (100%)	170 (10(

Source: Survey data

The above table 3.2.1 shows that among the adopters aggregate (personal and familial) percentage for illiterates is 53, followed by those, 14 per cent who have education up to primary level (I-V), another 25 per cent have education above primary and up to high school (VI-X) and only 8 per cent have education above high school level. However, within the adopters category as much as 73 per cent adopters themselves (self) are illiterate followed 11 per cent with education up to primary level, 15 per cent between VI-X and only 1 per cent have education above high school. However, only 33 per cent spouses (husbands) of adopters are illiterate followed by 17 per cent with education up to primary level, 37 per cent between VI-X and rest 12 per cent have education above high school level. In regard to their significant others, the table 3.2.1 shows that among the total significant others in adopters category (18), just half (50 per cent) are illiterate, followed by 17 per cent each in

remaining three categories i.e. I-V, VI-X, and above X. The table 3.2.1 also sheds light on the education profile of non-adopters. It can be inferred from the table that family aggregate education status of non-adopters is almost same rather slightly better than adopters. For example, among non-adopters the aggregate illiterate percentage is 49 (against 53 per cent of adopters), 20 per cent have education between I-V class (against 14 per cent of adopters) while 18 per cent have education between VI-X (against 25 per cent of adopters) and in above high school group there are 14 per cent non-adopters in comparison to 8 per cent adopters. Coming to differential education level of respondents, their husbands and significant others in non-adopters category, one finds that of the total non-adopter respondents 64 per cent are illiterate, followed by 20 per cent, 9 per cent and 7 per cent in I-V, VI-X, and above X groups respectively.

On further deconstruction of educational categories into illiterate, I to X and above X, one finds that family aggregate of adopters in illiterate category is 53 per cent (against 49 per cent of non-adopters), while in I to X, and above X category for adopters it is 39 per cent and 8 per cent respectively and in the same educational group their counterparts (non-adopters) are 38 per cent and 13 per cent respectively. Similarly, in the same revised grouping, 73 per cent of adopters themselves are illiterate (in comparison to 64 per cent non-adopters), 26 per cent have education between I to X (against 29 per cent non adopters) and finally in above X group only percentage of adopters is one (against 7 per cent of non-adopters). The same if stretched to spouses, one finds that 33 per cent husbands of adopters are illiterate (in comparison to 32

per cent spouses of non-adopters), followed by 54 per cent in I to X (against 48 per cent non-adopters husbands) and 12 per cent in above X group (against 20 per cent non-adopters counterpart). It may also be noted that in terms of personal and familial educational status of adopters and non adopters the t-values is significant for the husband of the adopters and non adopter with higher t- value for non adopters spouses (P = .004) than adopters husbands (P = .026).

It can thus safely be said that the data from present study do not show any significant relationship of education and sterilisation adoption. This puts it in the category of researches (as mentioned above) like that of Anker in Gujarat and Patel in Rajasthan where education did not have any significant bearing on fertility behaviour.

Occupation

Occupational composition is one of the crucial demographic variables which gives a fairly good indication of people's way of life, their educational and cultural status and their economic and social organization.[43] Mamdani[44] observed that the demand for population control may be rational in one class situation but not necessarily in another. For instance, he pointed out that in his study of Punjab villages, the wage earners and small farmers want large family

[43] S. Chandrasekhar, "The Composition of Population According to the 1951 Census, Part Ii," *Population Review* 2, no. 2 (1958)., cited in Joseph J. Spengler, "The Role of Agriculture in the Solution of Population Problem," in *Studies in Demography- Essays Presented to Professor S. Chandrasekhar on His Fifty-First Birthday*, ed. Ashish Bose, P.B. Desai, and S.P. Jain (London: Goerge Allen and Unwin, 1970)., pp. 59-64.

[44] Mahmood Mamdani, "The Ideology of Population Control," *Economic and Political Weekly* 11, no. 31-33 (1976)., p. 1147.

as children are viewed as a source of labour power, as an insurance against old age. So too is the case of the artisans employed in domestic industries who value children as economic assets. Nadkarni also saw the persistence of large families among cultivators than non-cultivators.[45] Samir Amin[46] adds value to this discussion and argued that 'having large families in an impoverished capitalist country is a form of economic rationality and not irrationality. Large families are often the best or only means of social security and old age pension in a neo-colonial situation.'

The table 3.2.2 shows personal and familial occupation diversity of adopters and non-adopters in the sampled population.

Table 3.2.2: Personal and Familial Occupational diversity of Adopters and Non Adopters

Occupation	Sterilisation status							
	Adopters				Non Adopters			
	Personal	Familial			Personal	Familial		
	Self	Husband	Significant Other	Total	Self	Husband	Significant Other	Total
Housewife/ No work	57 (76%)	6 (8%)	11 (61%)	74 (44%)	61 (81%)	10 (13%)	13 (65%)	84 (49%)
Agriculture, allied and unskilled work	5 (7%)	36 (48%)	4 (22%)	45 (27%)	6 (8%)	37 (49%)	3 (15%)	46 (27%)
Business	3 (4%)	14 (19%)	0 (0%)	17 (10%)	4 (5%)	9 (12%)	1 (5%)	14 (8%)
Service/ skilled work	10 (13%)	19 (25%)	3 (17%)	32 (19%)	4 (5%)	19 (25%)	3 (15%)	26 (15%)
Total	75 (100%)	75 (100%)	18 (100%)	168 (100%)	75 (100%)	75 (100%)	20 (100%)	170 (100%)

Source: Survey data

In terms of family aggregate across four occupational categories, among adopters family aggregate, 44 per cent falls in the category of housewife or no paid work while aggregate for counterpart non-adopters in the same category

[45] Nankarni, ""Overpopulation" and the Rural Poor."

[46] Samir Amin, "Population and Development," *Socialist Revolution* 6, no. 27 (1976)., pp. 77-79.

is 49 per cent. Further, 27 per cent of aggregate adopters (against equal that is 27 per cent non-adopters) are involved in agriculture, allied and unskilled works. In the business, and service/skilled work categories the aggregate adopters percentages are 10 (against 8 of non-adopters) and 19 (against 15 of non-adopters) respectively. Thus, there appears slight variation in aggregate occupation of adopters and non-adopters in business and service/skilled work category and can be extended to interpret that business, service/skilled work categories presents favourable conditions of sterilisation adoption than the housewife/no work or agriculture and allied works which do not differentiate much between adopters and non-adopters. Further, analyses of individual actors (self, husband and significant other) shows that 76 per cent of adopters themselves are in housewife/no paid work category (against 81 per cent non-adopters), followed by 7 per cent in agriculture and allied works (against 8 per cent non-adopters), 4 per cent in business (against 5 per cent non-adopters) and 13 per cent in service/skill work (against 5 per cent non-adopters). Thus among individual adopters and non-adopters personal characteristics, the relationship is significant only in housewife/no work and service/skilled work category (5 points) with inclination towards adoption. Interpreting the table 3.2.2 for the spouses of adopters and non-adopters, it comes that only 8 per cent adopters husband (against 13 per cent non-adopters) are in housewife/no paid work category, 48 per cent husbands of adopters (against almost equal 49 per cent non-adopters husbands) are engaged in agriculture and allied activities. Likewise, 19 per cent are in business (against 12 per cent of non-adopters) and rest 25 per cent (against equal non-adopters) are in service/skilled work category. Thus in the case of husbands of adopters and

non-adopters the difference appears more in business category (7 per cent margin). Further, in respect to significant others of adopters and non-adopters, the table informs that 61 per cent adopters significant others are in housewife/no paid work category in comparison to 65 per cent significant others of non-adopters in the same category. In other three categories, namely agriculture and allied business, and service/skilled work, the adopters significant others are 22 per cent (against non-adopters 15 per cent), nil (against non-adopters 5 per cent) and 17 per cent (against non-adopters 15 per cent) respectively. This shows that the significant others occupational involvement (in paid works) makes them positively related to sterilisation adoption. Further, the table 3.3.2 clearly shows that agriculture, allied and unskilled work category has similar percentage for adopters and non-adopters both as family aggregate and individually.

Income

A plethora of studies have analysed fertility-income calculus and came with interestingly results ranging from positive and negative extremes to zero value coefficients. For example, a plethora of studies[47] sounds (monotonically) of *high fertility in lower income groups* like Chandrasekhar and George for Bengal, Wyon and Gordon, and Mamdani for Punjab, Gaiha for all India rural households, NFHS-2 to mention few. In the same cadre there are those who

[47] Chandrasekaran and George, "Mechanisms Underlying the Differences in Fertility Patterns of Bengalee Women from Three Socio-Economic Groups.", Wyon and Gordon, *The Khanna Study : Population Problems in the Rural Punjab.*, Mamdani, *The Myth of Population Control : Family, Caste, and Class in an Indian Village.*, R. Gaiha, *On Measuring the Risk of Poverty in Rural India* (Delhi: Faculty of Management Studies, University of Delhi (Mimeograph), 1982)., International Institute for Population Sciences. and ORC Macro., *National Family Health Survey (Nfhs-2), 1998-99.*

dwelled more on rationale for high fertility among lower income groups. Rangarajan and Setia[48] have worked on the logic of underlying cost-benefit analysis and observed that the benefit of an additional child will depend upon the income level of the family, the higher the income level, the less will be the need for social security and therefore, the less will be the utility of the benefit of additional children and therefore, family size shrinks. Khan[49] in his study interestingly noted that the perceived economic status behaves differently in the two groups of Muslims. It is negatively associated with the use of contraception in the case of the MHO (Muslims with hereditary occupations) and positively in the case of the MNHO (Muslim with non hereditary occupations). The reason may be that in the traditional way of life among the MHO group, family planning is adopted only when their economic position forces them to do so. In contrasts, the MNHO group tend to adopt modern way of life as their income increases. However, the studies[50] like Mysore study, Mishra *et. al* study of UP and Rao study of Karnataka found *high fertility in high income groups* or primarily exploiting class. Another cadre of studies[51] report *low fertility in low-income groups*, for example Anker study of rural Gujarat, Patel study of Rajasthan village. There is also a cadre of studies[52] that

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[48] C. Rangarajan and J.K. Setia, "Population Policy and Redistribution of Income," *Economic and Political Weekly* 11, no. 31-33 (1976)., p. 1161.

[49] Khan, *Family Planning among Muslims in India.*, p. 165.

[50] U.N., "The Mysore Population Study.", Mishra et al., "Family Planning in Uttar Pradesh: A Change Programme and Its Clients.", Rao, "An Investigation into the Differential Behaviour of Economic Classes in Relation to the Family Planning Programme in Mandya District, Karnataka".

[51] R. Anker, "The Effect of Group Level Variables on Fertility in a Rural Indian Sample," *Journal of Development Studies* 14, no. 1 (1977)., Anker and Anker, *Reproductive Behaviour in the Households of Rural Gujarat.*, Patel, *Fertility Behaviour.*

[52] S.P. Jain, *Demography: A Status Study of Population Research in India*, vol. II (New Delhi: Tata McGraw Hill, 1975)., K.P. Singh, *Correlates of Fertility Behaviour* (New Delhi: Concept, 1986).

negate any significant variation in fertility across income variable in rural areas. Singh, for example, in her study of rural communities in Punjab and Haryana finds little variation in mean number of children across income groups. Jain has rightly contented that fertility differentials between different income groups in rural areas are small, especially because cultural practices, which are determinants of fertility behaviour, do not differ with change in income.

The income levels of the sampled population are shown in table 3.2.3. It shows that in terms of aggregate adopters groupings, 52 per cent are in the less than Rs. 1000 per month income slab (against 46 per cent non-adopters), while 17 per cent are in Rs. 1000-2000 income slab (against 19 per cent in non-adopters category), followed by 20 per cent (against 18 per cent non-adopters) and 11 per cent (against 16 per cent non-adopters) in the Rs. 2000-3000 and Rs. 3000 and above income slabs respectively.

Table 3.2.3: Personal and Familial Income levels of Adopters and Non Adopters

Income levels (Rs. per month)	Sterilisation status							
	Adopters				Non Adopters			
	Personal	Familial			Personal	Familial		
	Self	Husband	Significant Other	Total	Self	Husband	Significant Other	Total
Less than 1000	69 (92%)	10 (13%)	8 (44%)	87 (52%)	68 (91%)	10 (13%)	1 (5%)	79 (46%)
1000- 2000	3 (4%)	22 (29%)	3 (17%)	28 (17%)	7 (9%)	22 (29%)	4 (20%)	33 (19%)
2000 - 3000	2 (3%)	29 (39%)	3 (17%)	34 (20%)	0 (0%)	26 (35%)	5 (25%)	31 (18%)
3000- above	1 (1%)	14 (19%)	4 (22%)	19 (11%)	0 (0%)	17 (23%)	10 (50%)	27 (16%)
Total	75 (100%)	75 (100%)	18 (100%)	168 (100%)	75 (100%)	75 (100%)	20 (100%)	170 (100%)

Source: Survey data

Further, looking over individual (personal, spouse and significant other) income profiles in the same table 3.2.3, it comes out that 92 per cent of adopters themselves (against 91 per cent non-adopters) falls in less than Rs.

1000 income slab (which starts from zero). Likewise rest 4 per cent, 3 per cent and one per cent are in Rs. 1000-2000, Rs. 2000-3000 and Rs. 3000 and above income groups respectively. The rest of non-adopter women (9 per cent) fall in Rs. 1000-2000 income slab. Turning to their husbands, the data show that only 13 per cent husbands of adopters (against equal per cent of non-adopters spouse) fall in less than Rs. 1000 income slab. Another 29 per cent (against equal per cent of non-adopters spouse), 39 per cent (against non-adopters 35 per cent) and 19 per cent (against 23 per cent non-adopters) falls in income slabs of Rs. 1000-2000, Rs. 2000-3000 and Rs. 3000 and above respectively. Further, moving to significant others of adopters and non-adopters, one finds that 44 per cent adopters significant other (against 5 per cent non-adopters significant other) fall in less than Rs. 1000 income slab, followed by 17 per cent (against 20 per cent non-adopters) in Rs. 1000-2000 income slab and another 17 per cent (against 25 per cent non-adopters) and 22 per cent (against non-adopters 50 per cent) falls in the category Rs. 2000-3000 and Rs. 3000 and above income slabs respectively. Thus in totality both adopters and non-adopters represent the poorer segment of society. It may also be noted that research used a question on net saving but responses in more than 70 per cases were negative i.e. debt instead of saving. On being asked how they manage family expenses, if income falls short of expenditure and the response was uniform that they manage by taking the household necessary items on debt and repay the same latter on. It may also be noted that this phenomena is more persistent among agriculture, allied and unskilled workers who get work for not more than 20 days a month and as per work availability and resultant earnings they manage the family affairs. However, the relative percentage of

non-adopter's family aggregate is higher in higher income slabs than adopter's family aggregate. The t-test also shows significance of non-adopters aggregate family income ($t = 3.475$; $P = .040$) unlike the adopter's family aggregate incomes ($t = 2.743$; $P > .05$). Further, in case of incomes of husbands and more particularly of significant others, the variations are sharp among adopters and non –adopters. The result of t- tests show significance for the incomes of adopters husbands ($t = 4.432$; $P = .021$) and significant others ($t = 3.781$; $P = .032$). Thus, it may be inferred that unlike Malthusians and neo-Malthusians non-stop cry the poor do not profligate rather poor are more prone to sterilisation as is clear from above discussions.

Thus, in view of data interpretation in above tables 3.1.1 – 3.2.4, and insight developed from focus group discussions (FGD 1-2) and case studies (CSN 1-4) it is clear that since women have to bear the brunt of child upbringing, pregnancies and experience family hassles owing to less income and more expenditure, they become much desperate to stop child birth. This is further exacerbated if mother is employed that also in works like skilled work/service which have a fixed schedule and also require long to and fro movements. The same employment also provides them exposure as well as boldness to finally stop birth, for which they recourse to sterilisation (most reliable and permanent solution). The variables like religion, caste, family type, occupation and income operate differentially to impede or proceed the process of contraceptive (more specifically sterilisation) adoption. The case studies also illustrated, how even the significant others with land holding but bearing the major responsibility of family expenses provides implicit consent (rather

support) to their daughter-in-laws to go for sterilisation. Even the political participation as a result of Constitutional Amendment is favourable to small family norm and contraceptive adoption.

To what extent and of what level child/pregnancy load becomes pinching to women and how the process of adoption moves in family matrix needs to be thoroughly investigated. The next chapters 4, 5 and 6 review the impact of reproductive trajectory women, and intra-house dynamics of communication and power relations and also the chapter 6 reflects how both variables operate differentially in terms of contraceptive typology that is temporary and permanent methods.

CHAPTER-4

RURAL WOMEN REPRODUCTIVE TRAJECTORY

CHAPTER-4

Rural Women Reproductive Trajectory

The reproductive pattern of our women is painted as-'too early, too soon, too many and too late.'[1] There is a widespread assumption that 'people in rural India go on producing children as long as they can'[2], and on the same token it is also argued that 'the early marriage provides a longer duration of procreation resulting in more child births and vice-versa'[3]. However, Patel counter these arguments and observed that even social onomastics in Mogra (her study village) reinforces ideas about desirability or otherwise of childbirth during certain stages in a couple's fertility trajectory.[4] Patel's study further shows that 'the couples know the permissible range within which their fertility behaviour can vary. They know when the number of children is less or more than required, and what their optimum number and sex composition should be. Even the young unmarried children know the fertility norms and react with surprise if other's fertility performance falls short of the customary

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[1] Talwar, "Determinants and Consequences of Rapid Population Growth.", p. 43.

[2] S. Enke, "The Economic Aspects of Slowing Population Grwoth," *Economic Journal* 76 (1966)., U.N., "Concise Report of the World Population Situation in 1970-75," (New York: United Nations, 1974)., M.E. Endres, *On Defusing the Population Bomb* (Cambridge: Mass Halstead Press, 1975).

[3] Wyon and Gordon, *The Khanna Study : Population Problems in the Rural Punjab*., David Goodman Mandelbaum, *Human Fertility in India; Social Components and Policy Perspectives* (Berkeley: University of California Press, 1974)., K. Mahadevan and M. Sumangala, *Social Development, Cultural Change and Fertility Decline* (New Delhi: Sage, 1987).

[4] Patel, *Fertility Behaviour*., p. 84.

expectations.'[5] Moreover, it is well known fact that apart from a certain proportion of women being absolutely sterile, not all among the rest retain their capacity to reproduce, throughout the entire reproductive age span, say 15-50 years[6]. Kale[7] analysis of female fecundity has revealed that 100 per cent of sampled women were still fecund at 15 years of age, which declines to 50.48 per cent at the mid point age 35.5 years and to 4.76 per cent at 45.5 years and rest at 0 per cent at 50 years of age. To him 'it seems that at each step through this period, a certain proportion of women fallout of the fecund group, having lost their capacity to reproduce from that time onwards, the last woman succumbing around age 50.'[8] On the rural Indian pattern of reproduction Talwar[9] quotes from the 1991 Census that on an average about half of a child is born by the age of 19, then the pace of reproduction gets accelerated to almost one additional child for the next two five-year periods, namely 20-24, and 25-29. Then again, the pace of reproduction declines after age of 30 and only half a child gets added in the next two age groups. Similar analysis by Pathak and Singh[10] for the period 1972-92 shows that more than 50 per cent of births occur to women in peak ages between 20 and 30 years. They further noted that the maximum fertility declined at ages beyond 30 years, while teenage fertility (less than 20 years) over the period 1972-92

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[5] Ibid., pp. 86-87.

[6] Agarwala, *Some Problems of India's Population.*

[7] B.D. Kale, "A Female Fecundity Table," in *Studies in Demography- Essays Presented to Professor S. Chandrasekhar on His Fifty-First Birthday*, ed. Ashish Bose, P.B. Desai, and S.P. Jain (London: George Allen and Unwin, 1970).

[8] Ibid., p. 226.

[9] Talwar, "Determinants and Consequences of Rapid Population Growth.", p. 40.

[10] Pathak and Singh, "Fertility Transition in India.", p. 182.

remained almost unchanged. Visaria and Visaria[11] also observed that the level of fertility of married women has dropped considerably over the years, not because of any decline in fecundity or the capacity to reproduce but because of voluntary adoption or use of contraception by married couples. In terms of the present decisive age group of fertility, Pathak and Singh argued that in future the prospects of further fertility decline lie in the case of peak-age of fertility (that is women in 20-30 years).[12] However, Visaria and Visaria observed a shrink in this age group and argued that the peak fertility now occurs in the age group 20-24 and not in the next age group of 25-29.[13] Much earlier Bose also talked of 'project 1234'[14], which emphasized that governmental family planning efforts should start focusing from very young ages onto later ages that is women in the age group 12 to 34 in rural areas. It is noted that 'social and cultural factors dominate all other in affecting fertility'[15] and that the traditional societies are characterised by a pronatalist disposition. Studying human fertility in India, Mandelbaum[16] observed 'for a young wife, pregnancy is fine, the baby is fun, motherhood is grand and God given.' Very recently

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[11] Visaria and Visaria, "India's Population.", p. 72. They also noted like Pathak and Singh that the fertility decline is evident in all age groups, but particularly in the ages 30 and above.

[12] Pathak and Singh, "Fertility Transition in India.", p. 182.

[13] Visaria and Visaria, "India's Population.", p. 72.

[14] Bose, *From Population to People.*, p. xlv.

[15] WCED, *Our Common Future* (Oxford: OUP (World Commission on Environment and Development), 1987). Cited in Hari Mohan Mathur, "Social and Cultural Influences on Fertility Behaviour," in *The Family Welfare Programme in India*, ed. Hari Mohan Mathur (New Delhi: Vikas Pub. House in association with the HCM Rajasthan State Institute of Public Administration, 1995)., pp. 146-147.

[16] Mandelbaum, *Human Fertility in India; Social Components and Policy Perspectives.*

Patel in her Rajasthan study noted that 'motherhood is extolled, while barrenness is held as a curse.'[17]

4.1 Age at marriage

The age of marriage is defined as the age at which a woman starts cohabiting with her husband. It is a very important variable in explaining the fertility differentials. Studies have shown that it is negatively correlated with fertility.[18] However, Anker and Anker[19] in Gujarat and Patel[20] in Rajasthan found no clear relationship between age at marriage and fertility and that the correlation between age at marriage and fertility shows both positive and negative tendencies at the same time. Social and cultural factors have tended to support marriage at an early age for females in India. It could be expected that the effect of an increase in age at marriage on fertility would be to cut down the reproductive span.[21] It is observed 'since the female reproductive span is short and generally more fecund in its first than in its second half, postponement of marriage to ages beyond 20 tends biologically to reduce births. Sociologically, it gives women time to get a better education, acquire interests unrelated to the family, and develop a cautious attitude toward pregnancy.'[22] Talwar[23] analysis of data show that though there has been a decline in the incidence of marriage in the age group of 10-14 (from 19.2 per cent in 1961 to 6.2 per cent

[17] Patel, *Fertility Behaviour.*, p. 78.

[18] Khan, *Family Planning among Muslims in India.*, p. 49.

[19] Anker and Anker, *Reproductive Behaviour in the Households of Rural Gujarat.*

[20] Patel, *Fertility Behaviour.*, pp. 69-70.

[21] Raina, "Reseach in Family Planning.", p. 313.

[22] J. Blake, "World Population Conference, Belgrade-1965," (New York: United Nations, 1967). Cited in Davis, "Population Policy: Will Current Programs Succeed?.", p. 394.

[23] Talwar, "Determinants and Consequences of Rapid Population Growth.", pp. 37-38.

in 1981) but as high as 6 per cent girls still marry before the age of 15. Similarly, 43 per cent marry before the age of 20 years. The mean age at marriage for females rose from about 13 years in 1901 to 15.6 in 1951 and 18.3 in 1981. Visaria and Visaria noted in 1991, rural and urban female, on the whole, married at an average age of 19.0 and 21.3 years respectively, whereas the corresponding figures for males were 24.5 and 27.0 years.[24] In 1997 mean age at effective marriage for female at all India level is reported at 19.5 years.[25] From Radha Devi[26] analysis of data taken from the district level Rapid Household Survey conducted by Ministry of Health and Family Welfare, Government of India during 1997-99, it can be inferred that in Aligarh the percentage distribution of marriages of girls by categories child marriage, early marriage, acceptable marriage and preferred marriage is 5.3, 37.3, 34.3 and 22.7 respectively. The data analysis further shows that 48.3 per cent girls in rural and 20.0 per cent of girls in urban Aligarh marry before 18 years of age (legal minimum age).

In this study age at marriage for girls is classified into four categories[27] that are 10-14 years (child marriage), 15-17 years (early marriage), 18-19 years (acceptable marriage)[28] and 20 years and above (preferred marriage)[29]. The

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[24] Visaria and Visaria, "India's Population.", p. 71.

[25] GOI, "National Family Welafre Programme," in *Major Schemes and Programmes*, ed. Ministry of Health and Family Welfare (New Delhi: Department of Family Welafare, MOHFW, GOI, 2000)., p. 139. Also see http//: www.mohfw.nic.in

[26] D. Radha Devi, *Age at Marriage in India: Vision and Reality* (New Delhi: Serials Publications, 2006)., p. 102, 114.

[27] This four fold classification of marriages is borrowed from Ibid., p. 11.

[28] The Child Marriage Restraint Act, 1929 as amended in 1978 prescribes legal minimum age of marriage for girls and boys as 18 years and 21 years respectively (previously it was 14 years and 18 years for girls and boys respectively).

[29] The National Population Policy 2000 preferred marriage of girls after 20 years of age.

table 4.1 shows 21 per cent of the total sample population fall in the child marriage age group (10-14 years), while majority 55 per cent are in early marriage group (15-17 years) followed by only 18 per cent in legal marriage group (18-19) and only 7 per cent are in preferred group (20 and above).

Table 4.1: Distribution of Adopters and Non Adopters across Age at Marriage

Age at Marriage (Years)	Sterilisation status		Total
	Adopters	Non Adopters	
1. 10-14	15 (20%)	16 (21%)	31 (21%)
2. 15-17	41 (55%)	41 (55%)	82 (55%)
3. 18-19	11 (15%)	16 (21%)	27 (18%)
4. 20-22	8 (11%)	2 (3%)	10 (7%)
Total	75 (100%)*	75 (100%)	150 (100%)
Mean	16.1	15.8	15.9

Source: Survey data

The table 4.1 further informs that among adopters 20 per cent (against 21 per cent non-adopters) falls in 10-14 year age group, followed by 55 per cent, 21 per cent and 3 per cent in 15-17 years, 18-19 years and, 20 and above age group respectively. Similarly among non-adopters equal percentage (55) are in 15-17 years age group followed by 21 per cent and 3 per cent in the 18-19 years, and 20 years and above age group respectively. It may also be noted that in the last category 20 and above, all have married at 20 years of age except one in the adopter's category who married at the age of 21 years. It is also clear from the table 4.1 that substantial majority more than three-fourth marries by 18 years of age (legal minimum for women) and the figure is almost same for adopters (75 per cent), non-adopters (76 per cent) and total (76 per cent). Further, the mean age at marriage for total population comes to 15.9 years while for adopters it is 16.1 years and non-adopters it is 15.8 years. The sampled population mean age at marriage (15.9 years) falls below the state (UP) mean age at effective marriage for female which is 19.6 (against

19.5 for All India figures). In Kerala it is 22.0 years. In the sampled population now the practice of having girl's wedding (*vivāh*) at a very early age and then sending her to conjugal home after few years i.e. consummation of marriage (*gaunā*) has almost declined. We have come across only two such cases in which the difference exist in terms of effective age at marriage (consummation) and wedding, however for tabulating age at marriage we counted the former i.e. age at consummation. For example, Munni (refer **CSN-5**), a Hindu OBC woman had her wedding (*vivāh*) at the age of 9 years and was sent to conjugal home (*gaunā*) at the age of 13 years. She had her first birth at the age of 15 years and last at the age of 37 years. Similarly, Urmala (refer **CSN-6**) another Hindu OBC woman had her *vivāh* at the age 12 years and *gaunā* at 15 years of age. She experienced first childbirth at 20 years of age. Both the case studies formed the basis for understanding the pattern of age at marriage.

On the contrary the age of marriage of the sampled population husbands is relatively high, as much as 65 per cent of the husbands of total sample are in 20 and above age group and only 5 per cent are in 10-14 years age group (table 4.1.1).

Table 4.1.1: Distribution of Adopters and Non Adopters Spouse across Age at Marriage

Age at Marriage (Years)	Sterilisation status		Total
	Adopters	Non Adopters	
1. 10-14	2 (3%)	5 (7%)	7 (5%)
2. 15-17	14 (19%)	10 (13%)	24 (16%)
3. 18-19	10 (13%)	12 (16%)	22 (15%)
4. 20-22	31 (41%)	33 (44%)	64 (43%)
5. 23 and above	18 (24%)	15 (20%)	33 (22%)
Total	75 (100%)	75 (100%)	150 (100%)
Mean	20.8	20.4	20.6

Source: Survey data

The table further shows that among adopters 65 per cent are in 20 years and above age group (against 64 per cent non-adopters) and like wise 32 per cent are in 15-19 years age group (against 29 per cent non-adopters) and 3 per cent adopters and 7 per cent non-adopters are in 10-14 years age group. This small percentage do reflects that child marriages are still prevalent, no matter how much. The mean age at marriage of the sampled population spouses is 20.6 years and in terms of adopters and non- adopters spouses the mean ages at marriage are 20.8 and 20.4 years respectively.

In light of lengthy discussions with the subjects under study as well as with key informant and insight gained from case studies it can be argued that in the sampled population the most preferred age group for marrying daughters is 14-15 years and many respondents laments that under the prevailing circumstances it becomes very difficult to fine suitable groom at early ages. However, equally emphatically they argued that 16 years is the last age limit. Among all groups, Hindus, Muslims, general category, SCs and OBCs it was argued that '*solah last hai, hadd hai, sīmā hai, maa-bāp ko shadi/bihāy kar denā chāhiye*' (16 years is limit by which parents should marry off their daughters). It was told that even by the time girls reaches sixteen years of age, community 'talks' begins on 'why her daughter is not married' and to them 'this further exacerbate the chances of marriage' and that's why those who failed to marry early are married further lately. Therefore, girls are married at the earliest. Here, region/ community becomes important factor in deciding the notion of age at marriage of girls. All key informants corroborate and strongly certified and justified the community preferable age of marrying girls (14-15

years). They even questioning told thus '*isse jyada kya hogi*?' (What more age for marriage). Thus, to them this is the best and also the last age group for marrying their daughters. These discussions also expose the anomaly between the preferable age at marriage (20 and plus) expected from masses by the National Population Policy, 2000 and the preferable age at marriage in the region.

4.2 Marital duration

Patel study shows a positive correlation between marital duration and fertility. The modal fertility is in the 4-6 children group. The average fertility for mothers with 31 or more years of fertility exposure is seven children. Patel[30] further argued that the data does not support some demographer's view that 'rural couples procreate as long as they can. Younger as well as older mothers seem to be governed by common social norms constraining the former to procreate and the later to stop procreation'. On the basis of the evidence available in India, the average coital frequency is about 6 per month. There is evidence to indicate that coital frequency is higher in younger ages and among recently married couples and lower among older and longer duration couples.[31]

The table 4.2 shows that of the total sample (150), 47 per cent have marital duration of less than 10 years followed by 27 per cent in 10-20 years and another 19 per cent and 7 per cent in 20-30, and 30 and above years group

[30] Patel, *Fertility Behaviour.*, pp. 71-72.

[31] Nag, "Family, Type and Fertility"., p. 163.

respectively. Further of the total sample 53 per cent have marital duration of 10 years and more. With respect to adopters and non-adopters, difference in marital duration is quite apparent. Among adopters only 32 per cent have marital duration less than 10 years while among non-adopter the percentage of the same is high (63 per cent). Contrary to it, among adopters majority 68 per cent have marital duration in 10 and more year's group while for the same group non-adopters percentage is nearly half of adopters that is 37 per cent.

Table 4.2: Distribution of Adopters and Non Adopters across Marital duration

Marital Duration (Years)	Sterilisation status		Total
	Adopters	Non Adopters	
1. Less than 10	24 (32%)	47 (63%)	71 (47%)
2. 10-20	25(33%)	15 (20%)	40 (27%)
3. 20-30	20 (27%)	9 (12%)	29 (19%)
4. 30 and above	6 (8%)	4 (5%)	10 (7%)
Total	75 (100%)	75 (100%)	150 (100%)
Mean	16.1	11	13.5

Source: Survey data

The table 4.2 also shows that even as much as 8 per cent adopters and 5 per cent non-adopters are in 30 and above years marital duration group. The mean marital duration for adopters, non-adopters and total sample is 16.1, 11 and 13.5 years respectively. Thus it is quite clear that one goes for sterilisation only after substantial years of married life (mean 16 years of marital duration).

4.3 Age at first child birth

It is observed that the average age of women at first childbirth has shown an increasing trend during 1972-1991 in all the major states. But the change has been very nominal.[32] Patel in her Rajasthan study found that nearly fifty five

[32] Pathak and Singh, "Fertility Transition in India.", p. 184.

per cent women became mothers before crossing the age of 20, twenty eight per cent between 21 and 25 years and over four per cents after 25 years of age.[33]

In the total sample more than three-fourth (76 per cent) have their first child birth while in age group (15-20), followed by those 24 per cent who had first child birth in 20-25 age group while only 1 per cent respondent had their first child in 25-30 years age group (table 4.3).

Table 4.3: Distribution of Adopters and Non Adopters across Age at First childbirth

Age at First Child Birth (Years)	Sterilisation status		Total
	Adopters	Non Adopters[34]	
1. 15-20	57 (76%)	55 (75%)	112 (76%)
2. 20-25	18 (24%)	17 (23%)	35 (24%)
3. 25-30	0 (0%)	1 (1%)	1 (1%)
Total	75 (100%)	73 (100%)	148 (100%)
Mean	18.7	18.8	18.7

Source: Survey data

A high majority, as above table 4.3 shows, of both adopters (76 per cent) and non-adopters (75 per cent) experienced first childbirth in the age group 15-20 years. Rest (24 per cent) among adopters experienced first childbirth in the age group 20-25 years and same is almost true for non adopters (23 per cent) except 1 per cent (1) who had her child birth while in 25-30 years age group. The mean age at first childbirth for the sample as whole is 18.7 and for both adopters and non-adopters also it is just equal i.e. 18.7 and 18.8 respectively.

[33] Patel, *Fertility Behaviour.*, p. 58.

[34] Two women among non-adopters did not experience any childbirth and hence here total is 73 against 75 non-adopters respondents.

4.4 *Age at last child birth*

Pathak and Singh[35] in their analysis of fertility data from 1972-91 observed a significant change in the mean age of the women at the last birth. For example, in the case of Rural India, the mean age at the last birth was estimated to be around 38 in 1972 which reduced to 31 years in 1991. In the case of rural Kerala, the mean age at last birth was estimated to be 37 in 1972 and 29 in 1991. In the case of rural Uttar Pradesh, however, it was 40 years which has come down to 38 in 1991.

The table 4.4 sheds light on the distribution of ages across last childbirth. Here of the total sample 32 per cent had their last/youngest child[36] while they themselves were below 25 years and rest (69 per cent) after 25 years and more age groups.

Table 4.4: Distribution of Adopters and Non Adopters across Age at Last/youngest childbirth

Age at Last Child Birth (Years)	Sterilisation status		Total
	Adopters	Non Adopters	
1. 15-20	0 (0%)	13 (18%)	13 (9%)
2. 20-25	12 (16%)	22 (30%)	34 (23%)
3. 25-30	35 (47%)	22 (30%)	57 (39%)
4. 30 and above	28 (37%)	16 (22%)	44 (30%)
Total	75 (100%)	73 (100%)	148 (100%)
Mean	30.4	26.4	28.4

Source: Survey data

The table 4.4 also shows that none of the adopters had their last childbirth while in 15-20 years age group. Only 16 per cent adopters had their last

[35] Pathak and Singh, "Fertility Transition in India.", p. 184.

[36] Last and youngest child distinction is for adopters and non-adopters respectively. As in case of sterilisation (assumed to be successful), youngest child is the last child as it is irreversible method of contraception while in case of non-adopters, it is better to refer last child at the time of survey as the youngest child.

childbirth in their 20-25 years ages and 47 per cent in 25-30 years age group followed by 37 per cent who had last childbirth in 30 and above age group. Against the widely prevalent notion of sterilisation after 30 years age, it is at least encouraging to have 47 per cent respondent in the adopters category to have last child birth in 25-30 years age group. However, the mean age at last childbirth among adopters come to 30.43 years. Among non-adopters 48 per cent are in below 25 years (at the time of youngest childbirth) and rest 52 per cent are in 25 years and more age group. The mean age for at youngest childbirth among non-adopters is 26.4 years while for the total sample it is 28.4 years. Two young ladies among non-adopters did not experienced childbirths. Suman aged 19 years and married at 18 years is having her six months first pregnancy. While Ruhafza aged 20 years and married at the age of 18 is yet to experience a pregnancy. She is much disturbed on not bearing a child/pregnancy even after two years of marriage. She got much emotional moment, we asked about her parity. She shared that now she has started encountering a series of questions/whispers/stories as why she has not bore childbirth after two-year of marriage? Like other regions of India, here too first pregnancy/childbirth is a test of one's fertility, which is expected, from women/newly-wed daughter-in-law, she also wants to pass it out at the earliest.

4.5 Average spacing between children

Several studies have shown birth intervals of 33 to 36 months for many Indian women, Raina attributes this partly to relatively long period of lactation and

delay in resumption of menstruation after termination of pregnancy.[37] Patel also noted breast-feeding as another important practice accounting for regulation of birth interval. In Mogra (her study village) people consider mother's milk as the only vital nutrient for the infant. This belief is so strongly ingrained that infants are not given water for a considerable duration that is for two or three months if the child is born in summer, and for four to five months if in winter.'[38] Patel concluded this practice of breast feeding on demand has an important bearing on prolonging the anavulatory period considerably.[39] The employment of post-partum sexual abstinence as a deliberate attempt at family limitation is also reported in many studies, for example Caldwell and Caldwell, and Page and Lesthaeghe for sub-Saharan Africa and Patel for Rajasthan.[40] Patel also draws attention to 'occasions' demanding short term abstinence among couples which include menstruation, sickness, mourning and religious ceremonies.[41] There is another restraint to promote birth interval and is reported from many parts of India that is 'the cultural values proscribe women from showing any initiative in sexual

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[37] Raina, "Reseach in Family Planning.", p. 319. On birth intervals Patel observed in Mogra, the average birth interval (locally *hoe)* for mothers who have given birth to more than one child is 27 months. A gap of about two years between the childbirths is considered the minimum in Mogra. See Patel, *Fertility Behaviour.*, pp. 172-173.

[38] Patel, *Fertility Behaviour.*, p. 174.

[39] Ibid., p. 175. The same is also reported in Khanna study where two years of breast feeding prevents early birth of the next child. See Wyon and Gordon, *The Khanna Study : Population Problems in the Rural Punjab.*, pp. 158, 168-169.

[40] H.J. Page and R. Lesthaeghe, eds., *Child Spacing in Tropical Africa: Traditions and Change* (London: Academic Press, 1967)., J.C. Caldwell and P. Caldwell, "The Role of Marital Sexual Abstinence in Determining Fertility: A Study of the Yoruba in Nigeria," *Population studies* 31 (1977)., Patel, *Fertility Behaviour.*

[41] Patel, *Fertility Behaviour.*, p. 174. She also noted that the first child birth is postponed by norms maintaining a time gap between *muklāwo* and childbirth. Usually the prescribed duration of such an interval is at least two years., p. 174.

matters.'[42] For the period 1972-91 Pathak and Singh[43] observed that the closed birth interval in circa 1972 was 3.6 years for rural India and 3.7 years for urban India. It increased marginally to 3.7 years for rural India and 4.7 years for urban India. In the case of Kerala, closed birth interval of 3.7 years for rural and 4.0 years for urban in 1972 has increased to 5.5 years in 1991.

However, in the study villages of Jalalpur sub-centre the spacing between the consecutive childbirths is quite low. Among adopters the average spacing is 2.29 years and in case of non-adopters the spacing between childbirths is 2.31 years.

4.6 Presently living children

Mukherjee[44] extensive review has shown that 'except for a thin social stratum which limit the production rate at 2 children, Indian couples *en mass* set limit to 4 children which is also the valid estimate of the average of the surviving children per couple of complete reproductive period.' It is also pertinent here to take note of alarming decline in the child sex ratio in 2001 Census.[45]

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[42] H. Gould, "Sex and Contraception in Sherpur: Family in a North Indian Village," *Economic and Political Weekly* 4 (1969)., Poffenberger, *Husband-Wife Communication and Motivational Aspects of Population Control in an Indian Village*., M.N. Rao and K.K. Mathen, *Rural Field Study of Population, Singur* (Calcutta: All India Institute of Hygiene and Public Health, 1970)., M. Nag, "Sex, Culture and Human Fertility: India and the United States," *Current anthropology* 13 (1972)., Patel, *Fertility Behaviour*., p. 174.

[43] Pathak and Singh, "Fertility Transition in India.", p. 184.

[44] Mukherjee, *Family and Planning in India*., p 29.

[45] India's leading demographer Ashish Bose commented on this event and note- I would like to coin another acronym- DEMĀRŪ where D stands for daughters and 'MĀRŪ' stands for killing. In English 'E" will denote 'elimination'. On the basis of statistical cut-off point of 50 points decline in the child sex ratio, I would classify Punjab, Haryana, Himachal Pradesh and Gujarat as DEMARU states. Also see Ashish Bose, "Census of India 2001 and After," *Economic and Political Weekly* XXXVI, no. 20 (2001)., p. 1687. Oldenberg has also referred to these classical regions i.e. north and west as the *Bermuda triangle* for missing females. See

Earlier high female mortality used to be attributed to 'preferential treatment to boys, especially in feeding and medication'[46] and now it may be due to the desire to have small family (but with social optimum number of sons) and hence sex-selective abortions (female foeticide replacing age old female infanticide)-'the direct blessing of unprecedented discovery of science and technology for the women'[47].

With respect to presently living children out of the total samples population, 21 per cent have 1-2 child parity while majority 71 per cent have 3-6 parity and there are also 8 per cent those who have 7 and more parity (table 4.5).

Table 4.5: Presently living children of Adopters and Non Adopters

Parity	Sterilisation status		Total
	Adopters	Non Adopters[48]	
1-2	3 (4%)	28 (39%)	31 (21%)
3-4	27 (36%)	24 (33%)	51 (35%)
5-6	37 (49%)	16 (22%)	53 (36%)
7-8	7 (9%)	2 (3%)	9 (6%)
More than 8	1 (1%)	2 (3%)	3 (2%)
Total	75 (100%)	72 (100%)	147 (100%)
Mean	4.8	3.4	4.1

Source: Survey data

V. Oldenberg, "Sex Ratio, Son Preference and Violence in India," *Economic and Political Weekly* 27, no. 49 (1992).

[46] M. E. Khan, "Women and Health- a Case Study of Sex Discrimination" (paper presented at the Joint ICMR-Ford Foundation Workshop on Child Health, Nutrition and Family Planning, Bangalore, 1983)., L. Visaria, "Levels, Trends and Determinants of Infant Mortality in India," in *Infant Mortality in India*, ed. S.P. Jain and P. Visaria (New Delhi: Sage, 1988)., Patel, *Fertility Behaviour.*

[47] Noor Mohammad and Mohammad Shahid, "Rethinking Women's Participation, Empowerment and Gender Equality: A Micro Analysis," *Women's Link* 10, no. 3 (2004)., p. 8. Also see Bose, "Census of India 2001 and After.", L.S. Vishwanath, "Female Foeticide and Infanticide," *Economic and Political Weekly* XXXVI, no. 35 (2001).

[48] As stated earlier two of the non-adopters do not have any childbirths while one lost her only child and thus in case of parity comparison the table 4.5 has a total of 72 non-adopters instead of 75.

Among adopters as the table 4.5 shows only 4 per cent have 1-2 parity (basically as data analysis reveal these 4 per cent are with 2 children rather than in 1-2 parity). A high majority 85 per cent have 3-6 parity (36 per cent in 3-4 and 49 per cent in 5-6 parity group). Remaining 10 per cent have 7 and more parity. Among non-adopters 39 per cent are in 1-2 parity group followed by 55 per cent in 3-6 parity groups (33 per cent and 22 per cent each in 3-4 and 5-6 parity group), and the rest 6 per cent are in 7 and more parity group. The mean parity for the total sample is 4.1 and in terms of adopters and non-adopters it is 4.8 and 3.4 respectively. The high figures of more than 2 parity in the total sample (79 per cent). Further the 96 per cent adopters have more than two child parity and in the same category non-adopters percentage is 61 per cent which are alarming given the government of India much publicized norm of two child and quest of reducing TFR at 2.1 to achieve replenishment level population growth.

4.7 Pregnancy outcomes and safe motherhood practices

The mortality (whether peri-natal, neo-natal, infant or child) has its own impact on fertility. Davis[49] noted the fear of invidious deprivation apparently has greater force, and hence the absolute level of living acts more as an environmental condition than as a subjective stimulus. Srinivasan further adds that the linkage of fertility to previous experience of infant and child mortality is one of the established facts of demography.[50] In fact several Indian

[49] Kingsley Davis, "The Theory of Change and Response in Modern Demographic History," *Population Index* 29, no. 4 (1963).

[50] K. Srinivasan, "Modernisation and Fertility Change: A Review of Theoretical Developments," in *Fertility and Mortality*, ed. K. Mahadevan (New Delhi: Sage, 1986)., pp. 173-174.

studies[51] for example the Mysore population study and Poffenberger's study in 1960s; the Khanna (Punjab) study and its restudy by Mamdani, Djurfeldt and Lindberg for south India during 1970s; Mishra *et. al* study in UP during 1980s; and more recently Patel's Rajasthan study in 1990s all have emphasized on the unlikelyness of parents in restricting the number of their children in wake of high infant mortality rate. Khanna study concluded until they (villagers) have good assurance that live born sons and daughters, will survive, couples in the Khanna area are unlikely to be interested in restricting the number of children beyond the present practice (4.7 living children). Djurfeldt and Lindberg argued that birth of 4-6 children is considered the *social optimum* [italics mine]. Mishra *et. al* noted that an infant mortality rate of 150 per thousand implies that a fourth of the children born will die before they attain their fifteenth birthday. Under such a high infant mortality rate, a parent would have at least four children to be sure that three children would survive to the age of fifteen years. Patel also argued that child survival is the more important dimension of fertility and even said it is meaningless to ask question about the desired family size unless it is seen in the light of real experiences of the family in the process of its reproduction under a particular set of objective conditions. She further observed that 'the social norms of fertility and the repository of experiences of past and present fertility and mortality continue to influence people's behaviour in favour of high fertility. The fear of child mortality continues to persist in the minds of the younger

[51] U.N., "The Mysore Population Study.", Poffenberger, *Husband-Wife Communication and Motivational Aspects of Population Control in an Indian Village.*, Wyon and Gordon, *The Khanna Study : Population Problems in the Rural Punjab.*, Mamdani, *The Myth of Population Control : Family. Caste, and Class in an Indian Village.*, Djurfeldt and Lindberg, *Pills against Poverty.*, Mishra et al., *Organisation for Change: A System Analysis of Family Planning in Rural India.*, Patel, *Fertility Behaviour.*

parents too' and on the basic of her analysis both at factual and perceptual level concluded that 'the common pool of historical experiences and folk wisdom expressed in the associated values, beliefs, and norms has a bearing on people's adjustment with and response to infant and child mortality.'[52] Contrary to these assertions are the views of Coale[53] and Glass[54] who feel that decline in mortality may not be a necessary and sufficient condition for fertility decline. They observed that in the case of Bulgaria, Spain and some other European countries fertility started declining while mortality was still high. On question of total number of live births and living children as variables Khan[55] noted that in explaining family planning attitude and behaviour of individuals, the number of living children is a much more sensitive variable than the total number of live births. It is the living children who represent economic pressures and satisfy the drives of parenthood. On the pregnancy load, Patel rightly observed that 'despite of presence of traditional support institutions, senior women feel crushed under the weight of repeated pregnancies and child deliveries. It is not uncommon to hear their experiences of pain and anguish. In most of these cases, they desire earnestly to seek respite from continuous reproduction. Women's unwillingness to bear more children finds expression in their constant crabbing and irritable behaviour. They often prefer to stop procreation even before attaining the status of

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[52] Patel, *Fertility Behaviour.*, p. 160, 161.

[53] Ansley J. Coale, "Factors Associated with the Development of Low Fertility: An Historic Summary" (paper presented at the World Population Conference, 1965).

[54] D.V. Glass, "Population Growth and Population Policy," in *Public Health and Population Change*, ed. M.C. Sheps *et. al* (Pittsburgh: University of Pittsburgh, 1965).

[55] Khan, *Family Planning among Muslims in India.*, p. 40.

mother-in-law especially after they have had the socially optimum number of children surviving.'[56]

Abortion remains a sensitive issue in most countries of the world, and has only recently received international attention as a public health issue. India pioneered in legalising induced abortion under the Medical Termination of Pregnancy (MTP) Act of 1971.[57] Abortion can be legally availed if a pregnancy carries the risk of grave physical injury to a woman, or endangers her mental health, or when pregnancy results from a contraceptive failure in a married woman, or from rape, or is likely to result in the birth of a child with physical or mental abnormalities. Abortion is permitted up to 20 weeks of pregnancy duration and no spousal consent is required. Swaminathan Committee (1994) report on draft population policy also focused on abortion and noted that another critical area deserving attention concerns the large number of unsafe abortions conducted by unqualified persons which has led to high morbidity and mortality among women.[58] According to the official estimates in 1996-97 about 4.6 lakh MTPs were performed in the country. Against that, an estimated 6.7 million abortions per year are performed in other than registered and government recognised institutions, often by untrained persons in unhygienic conditions.[59] A review of literature in 1998

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[56] Patel, *Fertility Behaviour.*, pp. 169-170.

[57] Leela Visaria et al., "Abortion in India- Overview and Synthesis of Emerging Issues from the Qualitative Studies," in *Abortion Assessment Project of India*, ed. CHEHAT and Health Watch Trust (CEHAT, Mumbai and Health Watch Trust, Jaipur; research study supported by MacArthur Foundation, 2004)., p. 1.

[58] Bose, "The Family Welfare Programme in India: Changing Paradigm.", pp. 26-27.

[59] M.E. Khan et al., "Situational Analysis of Medical Termination of Pregnancy Services in Gujrat, Maharastra, Tamil Nadu and Uttar Pradesh" (paper presented at the International Workshop on Abortion Facilities and Post-Abotion Care and Operation Research, New York,

indicated that 'morbidity and mortality from unsafe abortion remains a serious problem for Indian women 28 years after abortion was legalised in India.'[60] The studies conducted in Haryana, Karnataka, Maharastra, Gujarat, Andhra Pradesh and Tamil Nadu reported limiting family size or increasing inter-birth interval or when earlier child was too young as the main reasons for abortion.[61] It is also noted that the abortion is resorted to for pregnancy that occurs while women are waiting to undergo sterilisation.[62] 'A few women in the urban Gujarat study by Barua reported that they directly approached the chemist for drugs for abortion and were provided them. This issue, Visaria *et. al* noted, of availability of abortion efficient drugs with chemist needs to be probed further.'[63]

In the total sample from Jalalpur sub-centre child mortality is not so high as 82 per cent of sample did not experienced any child mortality. However, 14 per cent of sample did experience 1-2 child mortalities while 5 per cent have encountered 3-4 child mortalities (table4.6). Nevertheless, given the value of life and preventable nature of such mortalities, the same figure of 19 per cent

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19-21 January 1998). Cited in Visaria et al., "Abortion in India- Overview and Synthesis of Emerging Issues from the Qualitative Studies.", p. 1.

[60] Heidi Johnston, "Abortion Practice in India: A Review of Literature," in *Abortion Assessment Project* (India: Health Watch and CHEHAT, 1999).Cited in Visaria et al., "Abortion in India- Overview and Synthesis of Emerging Issues from the Qualitative Studies.", p. 4. Much earlier, Rhodes estimated from the report on confidential enquiries into maternal deaths in England and Wales that the chances of dying from an illegal abortion were twice those of dying from normal child birth. See P. Rhodes, *Abortions in Britain* (London: University of London, 1966)., cited in Rao, "Health and Educational Approach to Family Planning-a Review of Studies and Implications for Social Worker's Education.", p. 22.

[61] CEHAT and Health Watch Trust, "Abortion Assessment Project of India- Qualitative Studies," (CEHAT, Mumbai and Health Watch Trust, Jaipur; research study supported by MacArthur Foundation, 2004).

[62] Visaria et al., "Abortion in India- Overview and Synthesis of Emerging Issues from the Qualitative Studies.", p. 7.

[63] Ibid., p. 12.

child mortality is pinching enough to be taken into cognisance. Among adopters 84 per cent did not experienced any child mortality against 79 per cent non-adopters. Further, 14 per cent each among adopters and non-adopters experienced 1-2 child mortalities while 3 per cent in adopters and 7 per cent in non-adopters even experienced 3-4 child mortalities.

Table 4.6: Distribution of Adopters and Non Adopters across child mortality

No. of child deaths	Sterilisation status		Total
	Adopters	Non Adopters	
Nil	63 (84%)	58 (79%)	121 (82%)
1-2	10 (13%)	10 (14%)	20 (14%)
3-4	2 (3%)	5 (7%)	7 (5%)
Total	75 (100%)	73 (100%)	148 (100%)
Mean	0.29	0.44	0.36

Source: Survey data

Thus, adopters have relatively bettered in child mortality prevalence than non-adopters. It may be extended to infer that those with less child mortality have more chances to go for sterilisation. Many studies have highlighted, as noted above, the impact of child mortality in favouring high fertility. However, in our case as the quantitative as well as qualitative data (FGD-3) reflect that child mortality do not figure much in their decision and hence it will be too much of table 4.5.2 to say that 'lesser the child mortality higher the sterilisation' or vice-versa 'higher the child mortality, lesser the adoption'. Similarly in terms of pregnancy wastes (still births and abortions- both natural and induced) the **figure 4.1** and **figure 4.2** of adopters and non-adopters respectively throw light. These figures show that among adopters 12 per cent experienced stillbirths at least once, followed by 15 per cent those with at least one natural abortion and another 16 per cent had undergone at least once an induced abortion. Among non-adopters, the percentage of those at least once

experiencing stillbirths at least once are 5 per cent followed by 12 per cent with natural abortion and 3 per cent with induced abortion.

Figure 4.1: Pregnancy outcomes of Adopters

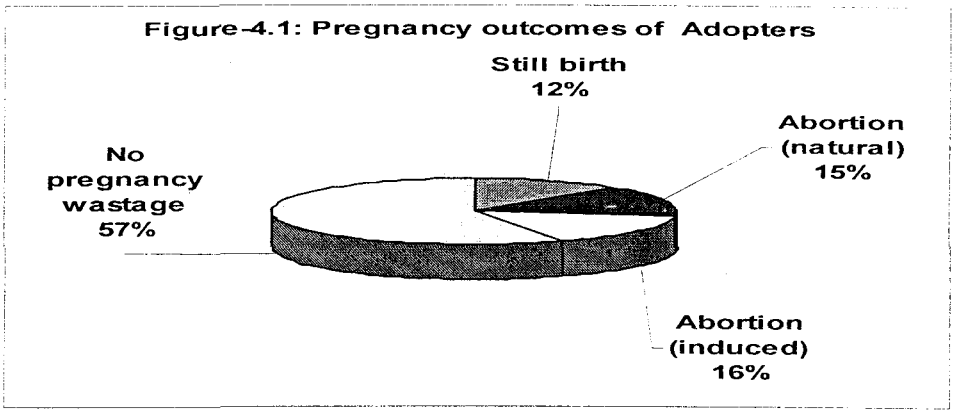
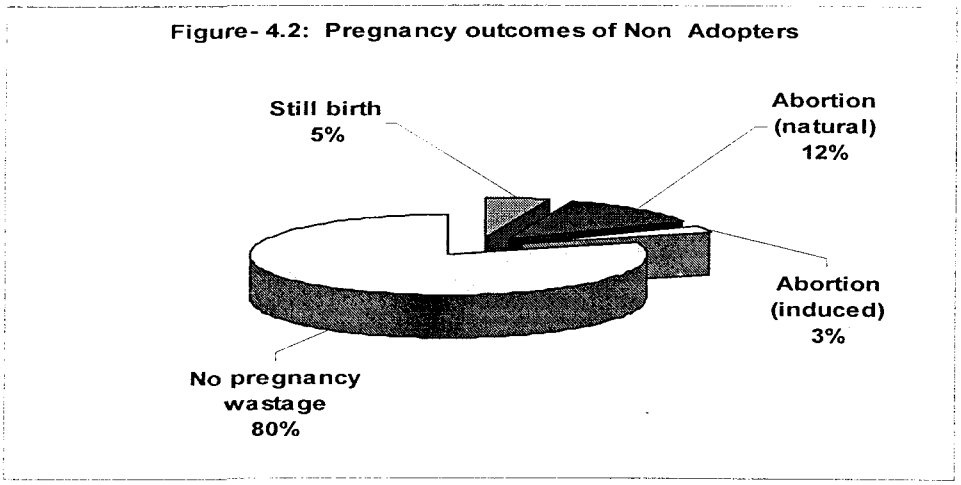


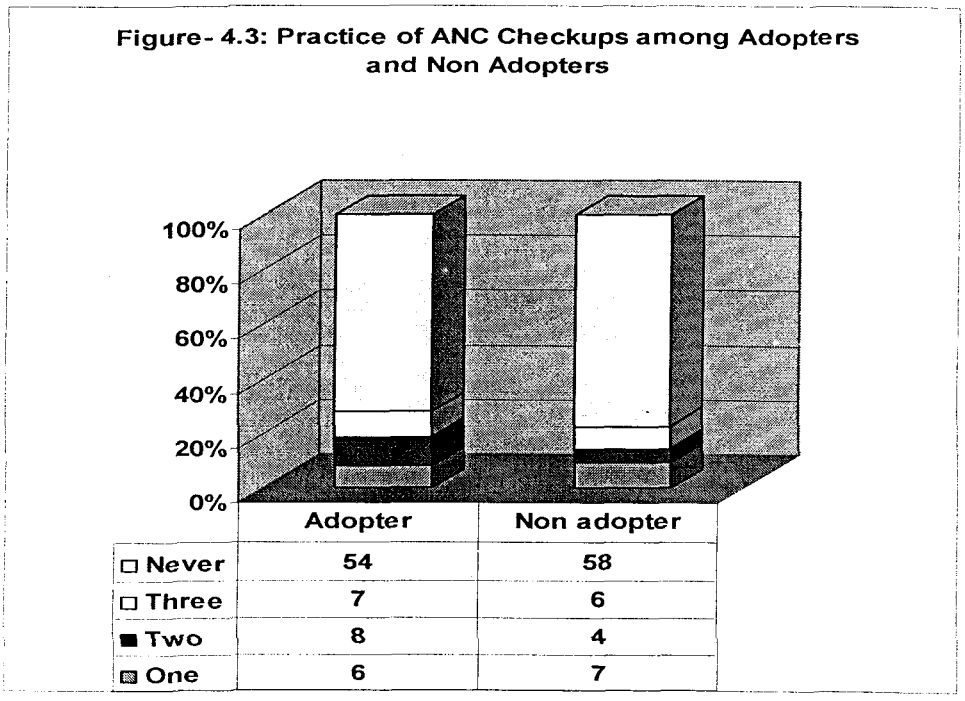
Figure 4.2: Pregnancy outcomes of Non Adopters



In the present study, the data relating to safe motherhood practices is also collected. The respondents were also asked about ever usage of safe motherhood practices viz. ante-natal checkups (ANC), intake of Iron, Folic Acid and Vitamin A (IFA) tablets and Tetanus Toxide (T.T.) injections and the usage of safe delivery practice - institutional deliveries, deliveries at home

by trained or untrained birth attendants and usage of safe delivery kits. With respect to ANC checkups out of the total sample only a quarter (25 per cent) have experience of ever ANC checkups and of these 14 per cent (21) are in adopters category while 11 per cent (27) are in non-adopters category (**figure 4.3**). Further, among adopters, a small 9 per cent have ever gone for complete three ANC checkups, while 11 per cent had ever two checkups, 8 per cent with only one checkup and remaining 72 per cent never experience any ANC checkups all through their reproductive career (in case of non-adopters here and afterwards till the date of field work). Similarly, among non-adopters the percentages of ever complete ANC checkups (i.e. three), two, one and never are 8 per cent, 5 per cent, 9 per cent and majority 77 per cent respectively.

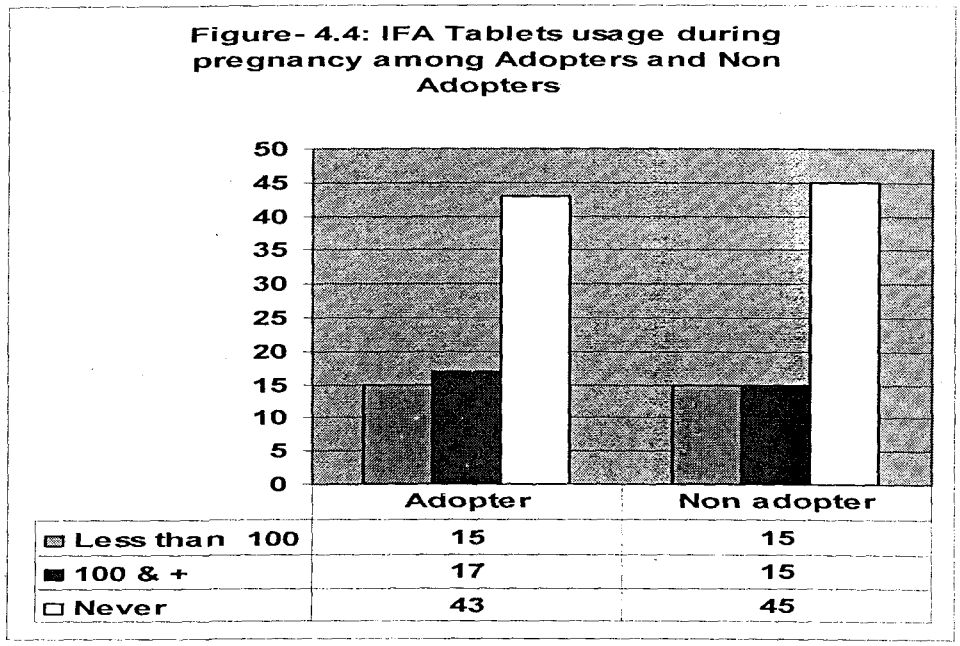
Figure 4.3: Practice of ANC checkups among Adopters and Non Adopters



Likewise in terms of IFA intake (which are given to supplement the Iron, Folic Acid and Vitamin A intake for pregnant women) only 41 per cent of the total

sample ever taken any IFA tablets (complete package immaterial), which are distributed free of cost at sub-centres and at any government health posts (**figure 4.4**). Among adopters, the percentage of those who have ever taken complete package of 100 or more IFA tablets is just 23 per cent while 20 per cent ever took less than 100 IFA tablets while majority 57 per cent never took any IFA tablets. Among non-adopters, the percentage of ever complete package IFA intake holders is 20 per cent, and equal are those who have ever taken less than 100 IFA tablets followed by 60 per cent never uses of IFA tablets.

Figure 4.4: Intake of IFA tablets among Adopters and Non Adopters



Coming to intake of T.T. injection given to pregnant mothers to save them and prospective child from tetanus, the data in **figure 4.5** show somewhat better (but not for applause) results with 63 per cent of those who have ever taken any T.T. injections (however, Government of India prescribed minimum is 80

per cent immunization of pregnant mothers). Among adopters percentage of those who have ever taken two or more injections is 59 (against 75 per cent non-adopters) while 2 per cent adopters have ever took only one T.T. injection in comparison to 7 per cent non-adopters. However, 39 per cent adopters and 36 per cent non-adopters never took any T.T. injection (which is also available free of cost at sub-centres and govt. health posts) in their reproductive career.

Figure 4.5: Intake of T.T. Injections among Adopters and Non Adopters

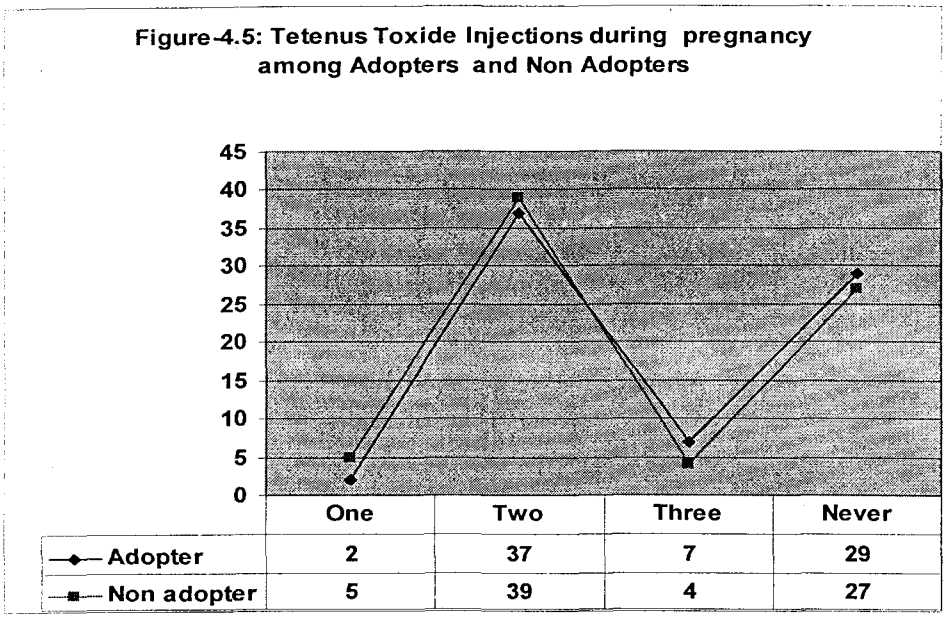
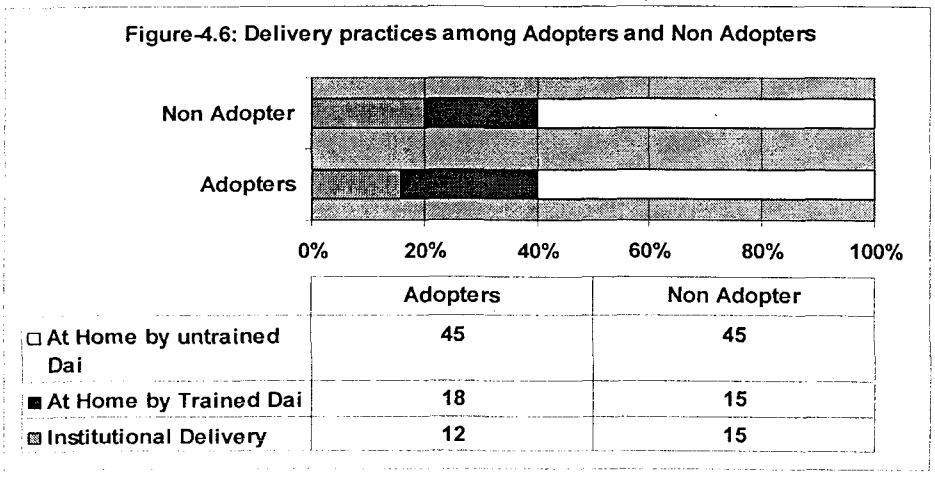


Figure 4.6: Delivery practices among Adopters and Non Adopters



In terms of safe delivery practices (**figure 4.6**) of the total sample only 18 per cent ever had any institutionalised delivery followed by 22 per cent those ever by trained birth attendant and a substantial 67 per cent ever experienced delivery at home by untrained birth attendants (*dai*). Among adopters percentage of ever-institutional deliveries, at home by trained birth attendants and by untrained birth attendants is 16 per cent, 11 per cent and 73 per cent respectively. Similarly, among adopters 20 per cent each have ever-institutional deliveries and at home by trained birth attendants and 60 per cent by untrained birth attendants. It is not simply, the question of the data quantum on ever deliveries by untrained or trained birth attendants at home but the manner in which deliveries are performed, the so called 'instruments' (*auzars*) used in delivery that are worth noticing to perceive the actual risks implicit in these deliveries. Equally important is to understand the rationale of low ANC and IFA intake and not so significant T.T. usage, which is almost a must. In order to understand the same the FGD was conducted which crystallized the underlying issues and is summarized here.

The aforesaid focus group discussion (refer **FGD-3**) was organised with a group of 15 women both adopters and non-adopters and their ages ranged from 20-45 years. The discussions dwelled on themes- ideal age at marriage, timings of first childbirth, their concern about child mortality, pregnancy load and wastage, safe motherhood and safe delivery practices in community and inherent risks and consequences. Researcher remains the key facilitator assisted and ably supported by ANM, ASHA and CMC. The discussion starts with significance of age at marriage of girls and boys. Group was anonymous

that the marriage of girls is a very important issue for parents and some added it is so right after the birth of girl child. Girls have to be married at the earliest by parents. For the boy's marriages there seems not much pressure however parents do consider it their responsibility to marry off their children before their eyes (that before their death). The elder ladies in the group emphasized on the responsibilities (*jimmedāri*), which should be performed as early as possible so is the marriage of children. The marriage of girls has another dimension it is also related with family prestige and capabilities. Thus group emphatically opined that in the region prescribed maximum is 16 years for girls (*hadd hai*) and their preferable age is 13-15 years. In fact as soon as girl starts menstruating (onset of puberty), mother take more initiative in pressing the father to find the suitable groom. On being asked about their education and effect on same due to early marriage they argued that we are not capable to allow boy's complete education, what to talk of girls. Education is costly and government schools are bad indeed lamented the group members. Many also lamented that they are not able to send all their boys to private good schools. Encouragingly, mothers seemed to be much concerned about the education and quality upbringing of children and were disappointed of their poor incomes and large number of children. Thus, group concluded that in case of girls, the early marriages (not child marriage) are most preferred (*jaisē samajhdār ho shādi kar do*). On childbirth after marriage, group energized to argue that 'it is no question, child is to be born' (*ye sawal nahi baccha hone hai*). They sarcastically argued 'what more will happen' (*aur kya hoga*). Basically they implicitly referred to cohabitation on the first night, which has a ritualistic significance (the night is called *shubh ratri*, pious night) and the

newly weds are facilitated for the same as soon as the groom's marriage party came back with bridegroom. On being facilitator group also argued that there are lot of expectations of elder parents to see their children's children (*nāti/pote*) and those who fail in begetting child as per expectations are being questioned implicitly initially, both inside and outside home, and latter on face wraths of elder family members and gossips outside the home. In such situations, the young daughter-in-law (*bahu*) faces major brunt. Thus the newly wed couples particularly female counterparts are also more desperate to procure child. In practice just after the calculated first trimester, community norms and rituals demand daughter-in-law to confirm that she is pregnant and then there are well defined norms for both young husband's and wife's families to contribute in first pregnancy declaration celebrations (*godd bharāi*). Thus, it is not only first childbirth but also the very first pregnancy marks rejoice. Those failing at childbirth after more than one year fall on the trap of ordeals (Ruhafza for example referred earlier). Elder ladies even justified the same by arguing that it is a question of maintaining family lineage (*kul /khāndān chalne ki bāt hai*). On the question of child mortality the group was not so perplexed, elders argued and remained of their childhood days high mortality and comparing the two argued that 'now there is not that mortality' (*ab kahan bacchē martēe hain*). Further on the question of pregnancy outcomes and wastes like live births, still births, abortions and maternal mortality deaths, the group was concerned but equally showed their helplessness and recourse in fate. They did share their and others anecdotes about pregnant mothers poor health and still births, abortions and delivery deaths. They also shared practice of secret induced unsafe abortions among

women in community, however, it ever remains to be a secret. Women of latter ages normally go for abortions when they are both fed up with number of pregnancies and understand un-affordability of any more child and are neither in a position to stop pregnancy (abstinence) nor to have sterilisation thus to them only choice is unsafe abortions which are done in nearby villages by old specialised ladies. They are charged Rs 150-300 and many times such unsafe abortions become miserably fatal. Group had many examples of women whose unsafe abortion resulted in life-death situations and the family was forced to invest as much as Rs. 4000-5000 (a very large amount for them). But group has pity for those women, as they are 'doing the same against life risk under extreme compulsions' (*khushī se nahi majboorī hai*). However, even on extensive probing group discredited the practice of sex selective abortion. Many do not know of ultrasound and like techniques but conscious that 'rich are doing the same' and even argued that 'what they are doing is wrong' (*galat kartē hai*). Group also had many examples of maternal deaths and explained highly unhygienic and risky deliveries that are undertaken at home. Most of deliveries at home are conducted at the neglected space of house by local *dai* (traditional birth attendant) without any safe delivery kits (which are now available at health posts free of cost). On close observation of such delivery sites in houses it came out that the conditions thereon exposes both the mother and child to the risk of hypothermia. New born babies vulnerabilities are further increased due to the practice of giving bathe to new born. Even, the umbilical cord is cut by the edge of broken tea cup/glass/or even used blade or like instruments, *aujars*. Most common cutting device is broken cup or used cup, which is first broken and than its 'sharp' edge is used

to cut the umbilical cord. The situations are further aggravated due to poor malnourished mother's health, no intake of IFA and T.T. injections. On being asked why they either don't take IFA from health worker and even if take than do not consume it. Group first lambasted on its non-availability (at that time, it was not available at sub-centre and ANM confirmed the insufficient supply but only for last few months). Then they argued differently. To some it results in vomiting and constipation and hence is not favourable (*sūt nahi kartī*), to others, it does not suit if taken without 'milk' and that's why many took one or two or even smelled it and left forever. When we told them that initially it creates such problems as iron is difficult to digest and in just few days all become normal and moreover, these IFA tablets provide a lot of supplementary intake much need to pregnant mother to save her and her child from anaemia and low birth weight respectively. Group acknowledged the same by showing their ignorance. It comes out that IFA tablets were just given to clients without any clarification about its initial responses, changes in body metabolism and probably due to the same reasons all in group heavily talked of IFA side-effects not of its benefits. Group showed their concern for T.T. injections and were also having repositories of new born child dying of tetanus and even told that they ask other women's to take T.T. injections but again they turned to non-availability of health services and for them it is unaffordable to go PHC at Block or District hospital for the same. Group also did not give much credit to ANC checkups as it requires investment, if not of services, them surely of moving from village to PHC or District Hospital in order to avail the same. On the question of pregnancy and its confirmation, group opined that once a woman misses her periods she becomes suspicious of

conception and then waits and even if periods did not return, they confirm themselves of the pregnancy. This is also the time when elder ladies not intending childbirth attempts to abort the child. Group was also much concerned about the plight of elder women with repeated pregnancies and according to them 'these results in increasing natural abortions, maternal death and even if she is alive, she is half alive'. It is under these circumstances that many times 'they ran away for sterilisation'.

Thus the tables 4.1-4.6, focus group discussions (FGD-3) and case studies (CSN 5-6) shows that the rural women reproductive career start with a challenging assignment of first childbirth immediately after marriage, those fortunate to pass it subsequently passes through a series of pregnancies and childbirths and becomes so susceptible that in spite of their willingness to not have any more child they are compelled to bear pregnancies to the extent that they themselves prefer unsafe abortion against an unwanted pregnancy. They do attempts tradition concoctions, and temporary contraceptives (if fortunate to avail) but unable to overcome risk of pregnancies either due to ineffectiveness of traditional concoctions or improper and irregular use of modern temporary contraceptives, if any, and finally their last resort is sterilisation. Thus, it is not that sterilisation attracts 'exhausted segment of reproductive group' but it is taken as 'recourse, respite and relief' by women from further pregnancies. The subsequent chapters will illustrate how many more children this 'exhausted segment may further add' had it not gone for sterilisation!

CHAPTER-5

DYNAMICS OF COMMUNICATION AND POWER RELATIONS IN CONTRACEPTIVE ADOPTION

CHAPTER-5

Dynamics of Communication and Power Relations in Contraceptive Adoption

A number of studies during 1950s-1970s have indicated a significant positive association between husband-wife communication and adoption of family planning.[1] It is supposed that the greater the communication between the spouses, the greater is the probability of their adopting family planning and greater the chance of their limiting the family size.[2] Patel, however, observed that the relationship between inter-spousal communication and fertility is not so clear.[3] Social behaviour of an individual depends very much on the way he perceives others. Theoretically, it can be expected that the spouses who perceive each other correctly, especially with regards to the desired number of children and family planning may differ in fertility behaviour from those spouses who do not perceive each other correctly. Mishra[4] in his study of the Negro population of Chicago found a positive relation between the degree of empathy and the adoption of family planning. Khan[5] also uses the same

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[1] For example Hill *et. al* in their study of Puerto Rico; Poffenberger in a Gujarat village; Dubey in urban Delhi; Mukherjee in his rural and urban samples of Haryana, Tamil Nadu and Meghalaya all noted a significant positive relationship between communication dynamics and family planning adoption. See Reuben Hill et al., *The Family and Population Control : A Puerto Rican Experiment in Social Change* (New Haven, Conn.: College & Univ. Press, 1959)., Mishra, "A Comparison of Husbands and Wives Attitude Towards Family Planning.", Poffenberger, *Husband-Wife Communication and Motivational Aspects of Population Control in an Indian Village*., D.C. Dubey, "Adoption of a New Contraceptive in Urban India," (New Delhi: Central Family Planning Institute, 1969)., Bishwa Nath Mukherjee, "Status of Women as Related to Family Planning," (Delhi: Council for Social Development).

[2] Khan, *Family Planning among Muslims in India.*, p. 51.

[3] Patel, *Fertility Behaviour.*, p. 85.

[4] Mishra, "A Comparison of Husbands and Wives Attitude Towards Family Planning."

[5] Khan, *Family Planning among Muslims in India.*, p. 165, 168.

husband-wife empathy index in Kanpur study and his regression equations find it as one of the 'equally important predictor of family planning acceptance'. More recently, Saraswati Raju[6] has made comments on the intra-house dynamics and noted if the gender relations are better, more open and egalitarian, it is easier for both men and women to achieve and maintain better sexual health and manage their reproductive lives free from coercion and fear; these were widely held social goals expounded upon at the 1994 International Conference on Population and Development (ICPD) in Cairo and the 1995 Fourth World Conference on Women in Beijing. Raju further argued that apart from intra-house dynamics of power relations and decision-making whereby men (along with other older members of family), seem to take most decisions including those related to reproductive health issues usually with adverse implications for women's health, other social changes warrant a redefining of traditional gender roles.[7] Neeraja[8] study of 800 fecund women in two districts of Andhra Pradesh shows that the decision in relation to family size limitation and contraceptive adoption still wrests with the husband alone (77 per cent). About 13 per cent of the couples were discussing among themselves to decide the contraceptive adoption. Jejeebhoy and others[9] noted the 'culture of silence' inhabit women from communicating a health problem or seeking prompt treatment unless it inhabits them from carrying out their daily chores. This 'culture of silence' is even more pronounced for gynaecological and

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[6] Saraswati Raju, "Negotiating with Patriarchy- Addressing Men in Reproductive and Child Health," *Economic and Political Weekly* XXXVI, no. 49 (2001)., p. 4589.

[7] Ibid., p. 4589.

[8] Neeraja, *Rural Women- Maternal, Child Health and Family Planning Services.*, p. 240

[9] Jejeebhoy et al., "Setting the Stage.", p. 9.

reproductive morbidity that are so closely linked with sexuality. Santha[10] outlining the key research areas notes that future research should explore the context in which women and men exercise choice, including the power dynamics of relationship, and the interface between clients and the service system.

This chapter explores the sampled population likeness of small or large family, rationales of ideal parity and more importantly intra-house dynamics of communication and power relations, which finally determines the end result of contraceptives adoption.

5.1 Rationale of Ideal family and Parity matrix

Most of the studies in India as well as other developing countries have shown a gap in actual and desired family size.[11] Commenting on a similar inconsistency observed in Puerto Rico, Hill[12] says that such ambivalence about family size perhaps represents a transitional stage of attitude development in the society, between an unequivocal preference for large families and an unequivocal preference for small. The numerical statement of ideal family size perhaps does not represent a fixed choice of preferred family size so much as it does an attitude that is a compromise between the two extreme cultural values i.e. preference for small families and preference for

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[10] Santha, "Contraceptive Use Dynamics.", p. 43.

[11] Dubey, "Adoption of a New Contraceptive in Urban India.", p. 13. Khan study of Kanpur also highlights the gap between the ideal and the actual family size. See Khan, *Family Planning among Muslims in India.*, pp. 98-99.

[12] Hill et al., *The Family and Population Control : A Puerto Rican Experiment in Social Change.*

large families, held simultaneously by the individuals. Khan[13] observed that though several of them do not really want additional children, their motivation is not strong enough to implement their desire. Powerlessness, religious fatalism and lack of feelings of efficacy i.e. the inner conviction that one is able to control one's own destiny, are frequently demonstrated in their answers. Khan[14] in an earlier study of 5400 married couples selected from both rural and urban areas concluded that as long as children remain the main source of social security to the ageing parents and are regarded as the 'poor man's capital' the general tendency will be to prefer a large family to small one. Sarma and Jain[15] reported an average desire for 1.1 additional children for families with two children and both of them sons. Khan is rightly inferred that *the ideal family size seems to be the lower limit of their choice rather than the upper limit* [italics mine].[16] On the question of 'a few' and 'many' children, Khan's respondent showed considerable variations. On an average, a male respondent considered three, and the female respondent four children as 'a few'. More than five children were considered both by the male and female respondents as 'many' children.[17] On this question of number of children which constitute the ideal family many studies during 1970s have shown that 'a large united family can be better safeguard to status and interest'[18] and that

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[13] Khan, *Family Planning among Muslims in India.*, pp. 94-95.

[14] M.E. Khan, "Value of Children: Some Preliminary Observations from Indian Data" (paper presented at the General Conference of the International Union for Scientific Study of Population, Mexico city, 1977). Cited in Khan, *Family Planning among Muslims in India.*, p. 58.

[15] D.V.N. Sarma and Anrudh K. Jain, "Preference About Sex of Children and Use of Contraception among Women Wanting No More Children in India," *Demography India* 3, no. 1 (1974).

[16] Khan, *Family Planning among Muslims in India.*, pp. 99-100.

[17] Ibid., pp. 108-109.

[18] Mandelbaum, *Society in India.*

'bitter faction fights in villages are won by men, not contraceptives'[19]. Mamdani even noted that for the majority of villages, large families are not only advantageous but also necessary and people will accept an invitation like family planning only when it 'pays' for them to do so.

Moreover the typology of ideal family is also much influenced by the parity calculus of males and females. Mukherjee[20] observed 'limiting the family size is seen to be conditioned by desire of the people to have 'sons'. Almost all studies have revealed that minimum two sons were desired by overwhelming majority of couples studied from all sections.'[21] Khan[22] in his Kanpur study on a sample of 330 couple noted that the majority 63 per cent of the

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[19] Wyon and Gordon, *The Khanna Study : Population Problems in the Rural Punjab.*, Mamdani, *The Myth of Population Control : Family, Caste, and Class in an Indian Village.* The role that numbers play in village community was also highlighted by Srinivas in his study of the dominant caste. See Srinivas, "The Dominant Caste in Rampura."

[20] Mukherjee, *Family and Planning in India.*, p 29. Interestingly in early 1950s R.A. Gopalaswami, then Registrar General on India, came with concept of "improvident maternity" defined as 'a child birth occurring to a mother who has already given birth to three or more children, of whom at least one is alive' and argued that '*the occurrence of improvident maternity should evoke social disapproval as any other form of social self-indulgence* [italics mine].' Cited in Bose, "Studies in Demography.", p. 33.

[21] Mukherjee, *Family and Planning in India.*, pp. 30-35. A series of sociologists and anthropologists have highlighted the preference for sons in India, the prominent among those are- Luschinsky (1963) in Senapur village, Uttar Pradesh people worrying over the questions such as 'what will happen to my lineage if I have no sons? I want security of sons? Opler (1964) in his study of Madhopur village (Uttar Pradesh) saw the most fervent hope of the young wife is that she proves her worth to her husband's family by producing a healthy male child. Blaikie (1975) summed up reasons for the importance of sons in Indian culture that the sons are required to perform the last funeral rites (śraddha), attract dowries for the parents, provide economic and emotional security in old age, provide income and help in the house and bring prestige and local political power (and even protection against the treat of physical force in confrontation situations) to the household, the kinship group and caste. See Mildred Stroop Luschinsky, "Problems of Culture Change in Indian Village," *Human Organisation* 22, no. 1 (1963)., Morris E. Opler, "Cultural Context of Population Control Programme in Village India," in *Facts and Theory in Social Sciences*, ed. Earl W. Count and Gordon T. Bowles (Syracuse, New York: Syracuse University Press, 1964)., Piers M. Blaikie, *Family Planning in India: Diffusion and Policy* (London: Edward Arnold, 1975). More recently Chattopadhyay-Dutta (1995) sees the reason for strong son preference in the dowry system which is widely prevalent in India and seem to be flourishing even though legally it is prohibited. Purnima Chattopadhyay-Dutt, *Loops and Roots : The Conflict between Official and Traditional Family Planning in India* (New Delhi: Ashish Pub. House, 1995).

[22] Khan, *Family Planning among Muslims in India.*, pp. 105-107.

respondents showed preference for a male child, it also appears from their responses that at least one daughter is equally important for them. Further, the females had a stronger desire for a second son than the males. Thus, two sons constitute the cut-off point[23]. Patel even noted the persistence of this cut-off point among youngsters and cited the case of Buddha, a 13 years old boy who reminded her (Patel) that 'one son is no son just as one eye is no eye (*ēk ank mein ānk nee, ne ēk pūt mein pūt nee*).'[24] She further observed that 'although the son is valued more than the daughter, the birth of at least one daughter is considered ideal for every married couples.'[25] She also noted that '*as a first child even a daughter is welcome, although son is more so. This is because a couple's fertility is on test.* So the child's sex is secondary. Upon, the first childbirth, people generally inquire first about the health of the mother and the infant, and then about the latter's sex [italics mine].'[26] Bose[27] has come with another lexicon on child preferences and termed it as '*demographic fundamentalism*' which means the craze for sons and the relentless efforts to try and get a son even when five or six daughters are born. It is also pertinent here to take note of alarming decline in the child sex ratio in 2001 Census.[28]

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[23] Bose, *From Population to People.*, p. xlv.

[24] Patel, *Fertility Behaviour.*, p. 87.

[25] Ibid., p. 83.

[26] Ibid., p. 81.

[27] Bose, "The Family Welfare Programme in India: Changing Paradigm.", p. 8. Basu further qualifies the statement and argued that every observer or resident of the Indian scene has personal knowledge of at least a handful of homes where child bearing has continued mercilessly until a son has been born, even when this means a string of five, six or even seven and more daughters first. See Alka Malwade Basu, *Culture, the Status of Women and Demographic Behaviour- Illustrated with the Case of India* (Oxford: Clarendon Press, 1994)., Alka Malwade Basu, "Demand and Its Socio-Cultural Context," in *South Asia Study of Population Policy and Programmes*, ed. UNFPA (New Delhi, India: United Nations Population Fund, 1990).

[28] India's leading demographer Ashish Bose commented on this event and note- I would like to coin another acronym- DEMARU where 'D' stands for daughters and 'MĀRŪ' stands for killing. In English 'E" will denote 'elimination'. On the basis of statistical cut-off point of 50

Earlier high female mortality used to be attributed to 'preferential treatment to boys, especially in feeding and medication'[29] and now it may be due to the desire to have small family (but with social optimum number of sons) and hence sex-selective abortions (female foeticide replacing age old female infanticide)-'the direct blessing of unprecedented discovery of science and technology for the women!'[30]

The forthcoming tables 5.1.1 to 5.1.7 present the sampled population rationale and likeness for ideal family and gap between precept and practices when it comes to parity (more specifically son-daughter alignment) composition. The table 5.1.1 shows that among adopters total family aggregate (168), 85 per cent likes small family and rest (15 per cent) favours large size family. Further analyses in respect to personal (self) and familial (husband and other significant other) responses, the data in table inform that a high majority of 95 per cent adopters themselves like small family followed by similar likeness by 88 per cent husbands of spouse. However, the situation somehow reverses with 67 per cent of the total significant others (18) of adopters favouring large size families.

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points decline in the child sex ratio, I would classify Punjab, Haryana, Himachal Pradesh and Gujarat as DEMARU states. Also see Bose, "Census of India 2001 and After.", p. 1687. Oldenberg has also referred to these classical regions i.e. north and west as the *Bermuda triangle* for missing females. See Oldenberg, "Sex Ratio, Son Preference and Violence in India."

[29] Khan, "Women and Health- a Case Study of Sex Discrimination"., Visaria, "Levels, Trends and Determinants of Infant Mortality in India.", Patel, *Fertility Behaviour*.

[30] Mohammad and Shahid, "Rethinking Women's Participation, Empowerment and Gender Equality: A Micro Analysis.", p. 8. Also see Bose, "Census of India 2001 and After.", Vishwanath, "Female Foeticide and Infanticide."

Similarly among non-adopters, as table 5.1.2 shows the same family aggregate (85 per cent) favour small size family. Likewise among non-adopters themselves 96 per cent like small family followed by same likeness of 87 per cent non-adopters husbands. Again with respect to non-adopters significant others also, the pendulum shift towards large family likeness as 65 per cent non-adopters significant others like large size family.

Table 5.1.1: Adopters Personal and Familial response on Likeness of Ideal Family (i.e. small or large)

Likeness of Family	Adopters Likeness of Ideal Family (small or large)			
	Self	Husband	Significant Other	Total
Small	71 (95%)	66 (88%)	6 (33%)	143 (85%)
Large	4 (5%)	9 (12%)	12 (67%)	25 (15%)
Total	75 (100%)	75 (100%)	18 (100%)	168 (100%)

Source: Survey data

Table 5.1.2: Non Adopters Personal and Familial response on Likeness of Ideal Family (i.e. small or large)

Likeness of Family	Non Adopters Likeness of Ideal Family (small or large)			
	Self	Husband	Significant Other	Total
Small	72 (96%)	65 (87%)	7 (35%)	144 (85%)
Large	3 (4%)	10 (13%)	13 (65%)	26 (15%)
Total	75 (100%)	75 (100%)	20 (100%)	170 (100%)

Source: Survey data

It is now clear from tables 5.1.1 and 5.1.2 that both adopters and non-adopters themselves and their spouses favour small family, even if it is notional or symbolic. However, significant others (of both adopters and non-adopters) tilted towards large family size further supports the argument that senior generations (father-in-law, mother-in-law and like) are still titled towards large size. The data in above tables also supports the inferences drawn from previous chapter-3 FGDs and case studies that burden of responsibility influences opinion on likeness of small or large family (number of children

very specifically). The burden is that of pregnancies, child deliveries, child care and rearing as well as the increasing economic pressure, and as these are more experienced first by women both because of her biology and due to her role as family manger. The same is reflected in highest percentage of small family likeness by women followed by spouse and negligible significant others. However, to understand the issue more clearly, we need to find answers to questions – what are the reasons for likeness, and what is the ideal parity composition. The tables 5.1.3-5.1.4 give answers to first question while tables 5.1.5-5.1.7 answer the second one.In terms of reasons for small family likeness the tables 5.1.3 and 5.1.4 shows that an aggregate 48 per cent adopters (against 46 per cent non-adopters) like small family because it is difficult to afford many children, while to another 46 per cent adopters (against 54 per cent non-adopters) like small family because they want quality upbringing of their children and a small 6 per cent in aggregate adopters argued that small families contribute to nation's development.

Table 5.1.3: Adopters Personal and Familial rationale/reasons for favouring small or large families

Reasons for Likeness	Personal and Familial Domain			Total
	Self	Husband	Significant Other	
Likeness for Small family				
1.Difficult to afford many children	31 (44%)	36 (55%)	2 (33%)	69 (48%)
2. Wants quality upbringing	35 (49%)	28 (42%)	3 (50%)	66 (46%)
3. Nations development	5 (7%)	2 (3%)	1 (17%)	8 (6%)
Total	71 (100%)	66 (100%)	6 (100%)	143 (100%)
Likeness for Large family				
1. More hands more income/ power	2 (50%)	4 (44%)	1 (8%)	7 (28%)
2. Security in old age	1 (25%)	3 (33%)	9 (75%)	13 (52%)
3. Children gift of God	1 (25%)	2 (22%)	2 (17%)	5 (20%)
Total	4 (100%)	9 (100%)	12 (100%)	25 (100%)

Source: Survey data

Thus, in terms of aggregate adopters and non-adopters reason for liking small family, almost majority favours it (94 per cent among adopters and cent per cent among non-adopters), either because too many children are unaffordable or because they want quality upbringing, which only qualifies the first one. The differential figures for self, husband and significant others also show similar results. For example the tables 5.1.3 and 5.1.4 also show that 93 per cent adopters themselves (against their cent per cent non-adopters counterpart), followed by 97 per cent their husbands and 83 per significant others (against cent per cent husband and significant others of non-adopters) favour small family for above two reasons – difficult to afford too many children, and want quality upbringing.

Table 5.1.4: Non- Adopters Personal and Familial rationale/reasons for favouring small or large families

Reasons for Likeness	Personal and Familial Domain			Total
	Self	Husband	Significant Other	
Likeness for Small family				
1.Difficult to afford many children	34 (47%)	30 (46%)	2 (29%)	66 (46%)
2. Wants quality upbringing	38 (53%)	35 (54%)	5 (71%)	78 (54%)
3. Nations development	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Total	72 (100%)	65 (100%)	7 (100%)	144 (100%)
Likeness for Large family				
1. More hands more income/ power	1 (33%)	3 (30%)	4 (31%)	8 (31%)
2. Security in old age	1 (33%)	4 (40%)	6 (46%)	11 (42%)
3. Children gift of God	1 (33%)	3 (30%)	3 (23%)	7 (27%)
Total	3 (100%)	10 (100%)	13 (100%)	26 (100%)

Source: Survey data

Interestingly, only among adopters category, 7 per cent adopters themselves, 3 per cent their spouses and 17 per cent significant others favours small family because it contribute to nation's development. The reason is cited by adopters and their family members (though negligible), to probably show that by

undergoing sterilisation they have fulfilled a responsibility ordained by government to control population and accept family welfare programmes.

Further among those who like large family the family aggregate total among adopters is 25 while among non-adopters almost same that is 26 (tables 5.1.3 and 5.1.4 respectively). Within this small number of family aggregates, 28 per cent adopters (against 31 per cent non-adopters) like large family as 'more hands provide more income/power' while 52 per cent among adopters (against 42 per cent of their non-adopters counterparts) like large family as children provides security in old age, and last there are also 20 per cent aggregate in adopters (against 27 per cent non-adopters) say that children are gift of God. In terms of individual break of reasons of large family, 75 per cent of adopters themselves out of those who likes large family (against the similar 66 per non-adopters) like it because more hands provides more income/power, and security in old age while 25 per cent of them (against 33 per cent non-adopters) favours large family as children are gift of God. Turning to their spouses who like large family, it comes that 77 per cent of them (against 70 per non-adopters counterpart) like large family for above two reasons and rest of spouses of adopters (22 per cent) and non-adopters (30 per cent) like large families, as children are gift of God. Similarly, out of those significant others, of both adopters and non-adopters who like large family, it comes that 83 per cent among adopters and 76 per cent among non-adopters like large family because more children provide more hands for income/power, and old age security while only 17 per cent of those in adopters family and 23 per cent in non-adopters family argues that children are gift of God. The tables (5.1.3 and

5.1.4) also inform that the significant other's major reason for favouring large family is security in old age (it is 75 per cent among adopters significant others and 46 per cent among non-adopters family). It can safely be infer that significant others are more concerned about old age security (which given the poor implementation of Government of India limited old age support system and general disarray of social welfare system in practice) is bound to logical percolate). It may also be noted that reasons like 'division of land' as factor for favouring small family did not figure in the sampled population, which again is quite obvious owing to the poor economic conditions of sampled population. However, even those few, with 25-109 *bigas* of land did not cite it, hence it is dropped in final tabulation. Similar among the reasons to favour large family, the reason like 'not sure of child survival' and hence large family to be on safer side, did not come across in sampled population and get zero value and hence dropped. This again justified the previous conclusion that unlike the previous studies and studies in other states, in the sampled population 'child mortality' or the 'child survival' issue is not significant, at least, a factor in deciding the size of family and adoption of family planning.

However, another important question, raised earlier, is the notion of 'ideal parity' and schism in precepts and practices. The table 5.1.5 shows that on the issue of ideal parity majority 52 per cent among adopters themselves favour a parity composition of two males and one female child and similar is the case of non-adopters where majority among them (44 per cent) favour the same parity while 48 per cent aggregate adopters and non-adopters favour the same parity composition (two males and one female). Further, the table 5.1.5 shows

that 21 per cent adopters (against 5 per non-adopters) favours 2 children but with a prescription of one male and one female. Further only 1 per cent among adopters (against 25 per cent non-adopters) argued for just two children but only males and even 17 per cent adopters (against 15 per non-adopters) favour an equal parity composition of 2 males and 2 females.

Table 5.1.5: Adopters and Non Adopters on Ideal parity composition

Parity composition	Sterilisation status		Total
	Adopters	Non Adopters	
1. Two (1Male- 1 Female)	16 (21%)	4 (5%)	20 (13%)
2. Two children (only Males)	1 (1%)	19 (25%)	20 (13%)
3. Two Males – One Female	39 (52%)	33 (44%)	72 (48%)
4. Two Males – Two Females	13 (17%)	11 (15%)	24 (16%)
5. Three Males –One Female	1 (1%)	5 (7%)	6 (4%)
6. Three Males – Two Females	4 (5%)	1 (1%)	5 (3%)
7. More than Three Males and Two Females	1 (1%)	2 (3%)	3 (2%)
Total	75 (100%)	75 (100%)	150 (100%)

Source: Survey data

Further, there are also aggregate 9 per cent (7 per cent adopters and 11 per cent non-adopters) who are bold enough to favour compositions like 3 males and 1 female (aggregate 4 per cent), 3 males and 2 females (3 per cent) and more than 3 males and 2 females (2 per cent). Thus, the last three rows of table 5.1.5 present a very high parity preference (against government norm of 2 children – male or female). It may also be noted here in bold letters that parity composition like only one child (male or female) or two children (male or female) do not figure in the sampled population. The forthcoming FGDs will crystallize how the parity composition is weighed and is uniformly persistent in sampled population across religion, cast, and other variables.

The tables 5.1.6 and 5.1.7 show the ideal parity compositions of adopter's and non-adopter's husbands and significant others respectively. The table 5.1.6

shows that the majority (48 per cent) of adopter's and non-adopter's husbands favour the parity composition of two males and one female, followed by 24 per cent favouring parity composition of only two children but one male and one female and another 15 per cent favours parity of 2 males and 2 females while the rest 4 per cent likes two children but only males and 9 per cent are those who favour parity composition of 3 males and 1 female, 3 males and 2 females, and even more (3 per cent in each category).

Table 5.1.6: Ideal parity composition of Adopters and Non Adopters husbands

Parity composition	Sterilisation status		Total
	Adopters	Non Adopters	
1. Two (1Male- 1 Female)	17 (23%)	19 (25%)	36 (24%)
2. Two children (only Males)	4 (5%)	2 (3%)	6 (4%)
3. Two Males – One Female	36 (48%)	36 (48%)	72 (48%)
4. Two Males – Two Females	10 (13%)	12 (16%)	22 (15%)
5. Three Males –One Female	1 (1%)	4 (5%)	5 (3%)
6. Three Males – Two Females	4 (5%)	1 (1%)	5 (3%)
7. More than Three Males and Two Females	3 (4%)	1 (1%)	4 (3%)
Total	75 (100%)*	75 (100%)*	150 (100%)

Source: Survey data

However, coming to aggregate of significant others (table 5.1.7), the likeness is more specific.

Table 5.1.7: Ideal parity composition of Adopters and Non Adopters Significant Other

Parity composition	Sterilisation status		Total
	Adopters	Non Adopters	
1. Two (1Male- 1 Female)	0 (0%)	0 (0%)	0 (0%)
2. Two children (only Males)	0 (0%)	0 (0%)	0 (0%)
3. Two Males – One Female	5 (28%)	7 (35%)	12 (32%)
4. Two Males – Two Females	6 (33%)	5 (25%)	11 (29%)
5. Three Males –One Female	0 (0%)	0 (0%)	0 (0%)
6. Three Males – Two Females	0 (0%)	0 (0%)	0 (0%)
7. More than Three Males and Two Females	7 (39%)	8 (40%)	15 (39%)
Total	18 (100%)	20 (100%)	38 (100%)

Source: Survey data

For example, 32 per cent favours parity composition of two males and 1 female, followed by 29 per cent of those who like parity of 2 males and 2 females and there are even the remaining 39 who like even more than 3 males and 2 females parity composition. Moreover, there are no variations in the ideal parity composition of adopters and non-adopters spouses and significant others.

Here it is also important to refresh back table 4.5 (in chapter 3), which shows the presently living children of adopters and non-adopters. The table 4.5 has shown that majority (71 per cent) aggregate adopters and non-adopters have 3-6 children. Turning to table 5.1.5, the aggregate parity composition of adopters and non-adopters in 3-6 children is 68 per cent. The difference in precepts and practices is more in two or less parity group. For example only 4 per cent of adopters are in parity group of 1-2 children (table 4.5) while there are 21 per cent adopters who like parity composition of two that also only of males (5.1.5). Similarly among non-adopters 39 per cent have presently living children in 1-2 parity while here only 5 per cent who like two children (that also males) this shows that they are still longing for more children. Thus a comparison of ideal parity (table 5.1.5) and presently living children (table 4.5) shows that while in reality adopters had undergone sterilisation at higher parity but now they show more concern to less parity compositions, probably to show their 'hyper concern' for government norm of two children to outsiders like researcher. This is reflected in comments like 'literates and well-off want small family of two children' (*pade likhe aur samradhe log do bacchon ka chottā pariwār chahtē hain*). On the other hand, non-adopters

particularly those with less children (with 1-2 parity group) long for more children in order 'not to have more children but parity prescription of requisite males and females'. Thus the data clearly reflect that, to people issue is not number of children but parity prescription that revolves around male child. The following case studies (**CSN- 7** and **CSN-8**) shed light on the notion of ideal family likeness and parity composition and how they are to not only abide by it but themselves are 'self-compelled' to maintain parity matrix. It also explains the quest for a male child (against irrespective number of girls), which is rightly dubbed as *demographic fundamentalism*. Meena (refer CSN-7) aged 35years is an illiterate non adopter and belongs to scheduled caste. Her husband aged 40 years is an unskilled worker and earns average Rs. 2500 per month. Couple lives in a nuclear family. Meena at persent has one son and four daughters (a parity of 5 children) but still longs for another son. Meena has her own logic for ideal parity composition and argues that the same is the social minimum expected from them. At the parity of five children she says her family is 'very small'. On being asked, she said after marriage daughters will go to their in-laws and we will be left with only one son. Is not this very small, she countered? She further continued to justify that she should have at least one more son to make the family complete. She even went to tell that even people do not take daughters from the families which do not have more sons as it is the son (prospective daughter-in-law's brother) who give warm reception (*agwāni*) to marriage party (*bārāt*). Further she argued that female children are not counted in family matrix. Thus to her, her family is very small with one son even with a total parity of five children!

This reminds of the customs and notions of family compositions prevalent in Rajasthan and Bose[31] and more recently by Patel[32] from their Rajasthan experiences. Bose was told by an old lady with a bold logic the notion of complete family. Lady said 'like without two eyes man is incomplete, so is the family without two sons'. Similarly, Patel was reminded of the importance of two sons by a 13 years old boy who argued, –'*ek ank mein ank nee, ne ek pūt mein pūt nee*' (one son is no son just as one eye is no eye). Similarly, Ramwati (refer CSN-8) aged 33 years, is an illiterate non-adopter living in joint family. Presently, she has only 2 daughters and in past her two children (one son and one daughter) have died. According to her 'family is counted on sons, a family is small irrespective of number of girls one have' (*parivār ladkon se hai, jitnī ladki ho parivār chhotā hai*). These case studies highlight and prove that even today family size is measured in terms of parity composition (as above data also support the same) rather than the numberof children one wants. It seems that still socially accepted minima is of two sons with a preference for at least one daughter.

5.2 Communication Domains and Decision Making

Khan[33] noted that in his study a number of female respondents were highly motivated to adopt family planning but their husbands did not want to do anything and because of lack of communication they were not even able to express their desire to their husbands. In the present research an endeavour is

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[31] Bose, *From Population to People.*

[32] Patel, *Fertility Behaviour.*

[33] Khan, *Family Planning among Muslims in India.*, p. 174.

made to fathom the depth of communication (or communication domains) within the family. In sequel to understand same, the data regarding the communication domains was collected. The tables 5.2.1 and 5.2.2 show the intra-house dynamics of communication on family issues among adopters and non-adopters. In order to explore the gravity and variation in intra-house dynamics six issues are taken viz. routine domestic problems, economic issues, child upbringing, personal health and hygienic, idea of having small family and lastly, limiting family size. The table 5.2.1 informs that among adopters discussion on almost every issue with husband is high and varies from 69-85 per cent. The issue on which they least discuss with others and confine to themselves is issue of personal health and hygiene (25 per cent). A high majority (83 per cent) of adopters discuss the idea of small family size with their husbands while even more, 85 per cent discuss the issue of limiting family size with their husbands. The discussion percentage with significant others is less (may be owing to their less number) however within them a highest of 11 per cent adopters discussed economic issues with their significant others.

Table 5.2.1: Family Issues and Intra house dynamics of communication among Adopters

Family Issues	Discussion with family members			Total
	Self only	Husband	Significant Other	
1. Routine domestic problems	9 (12%)	59 (79%)	7 (9%)	75(100%)
2.Economic issues	6 (8%)	61 (81%)	8 (11%)	75 (100%)
3. Child upbringing	7 (9%)	61 (81%)	7 (9%)	75 (100%)
4. Personal Health & Hygiene	19 (25%)	52 (69%)	4 (5%)	75 (100%)
5. Idea of having small family	10 (13%)	62 (83%)	3 (4%)	75 (100%)
6. Limiting Family size	8 (11%)	64 (85%)	3 (4%)	75 (100%)

Source: Survey data

In the case of non-adopters, first thing to note is that they also discussed all issues including idea of small family and limiting size, inspite of fact that three non-adopters do not have any child while 39 per cent of them have parity if 1-2 children. This is an encouraging trend of increasing communication and consciousness of such issues. The table 5.2.2 shows that unlike adopters, non-adopters range of discussion with spouse varies from 35-79 per cent. Non-adopters have similar communication pattern of discussion on issues like routine domestic problems, economic issues and child upbringing, and on these issues they are ahead of adopters in discussing the matter with significant others (range 15-17 per cent while among adopters range is 9-11 per cent). However, in terms of issue like personal health and hygiene as much as 53 per cent confine it to themselves which in adopters case was 25 per cent. Further, only 53 per cent non-adopters (against 83 per cent adopters) discuss the idea of having small family with their spouse while 65 per cent (against 85 per cent adopters) discuss the issue of limiting family size with their spouses.

Table 5.2.2: Family Issues and Intra house dynamics of communication among Non Adopters

Family Issues	Discussion with family members			Total
	Self only	Husband	Significant Other	
1. Routine domestic problems	6 (8%)	56 (75%)	13 (17%)	75 (100%)
2.Economic issues	5 (7%)	59 (79%)	11 (15%)	75 (100%)
3. Child upbringing	10 (13%)	54 (72%)	11 (15%)	75 (100%)
4. Personal Health & Hygiene	40 (53%)	26 (35%)	9 (12%)	75 (100%)
5. Idea of having small family	28 (37%)	40 (53%)	7 (9%)	75 (100%)
6. Limiting Family size	19 (25%)	49 (65%)	7 (9%)	75 (100%)

Source: Survey data

However, on these three issues that is personal health and hygiene, idea of small family and limiting family size, non-adopters range of discussion with

significant others is 9-12 per cent, which is ahead of adopters 4-5 per cent only.

Thus, it may be inferred that adopters have larger mutual communication than non-adopters. However, this statement should be read with a caution that the adopters after being sterilised show a tendency to be more vocal, open and bold on these issues, which they might not have been earlier. Nevertheless, both tables do reflect an increasing pattern of mutual discussions of all matters including family size and family limitation, which contradicts the argument regarding absence of communication among husband and wife (not to talk of significant others) on issues like having small family and limiting family size.

However, discussion on issues in one thing and final decision making on the same is another and our sample shows quite clear-cut pattern. Irrespective of with whom it is discussed or not, for its execution it depends on family decision-maker. The tables 5.2.3 and 5.2.4 illustrate the intra-house power dynamics on these issues among adopters and non-adopters respectively. The table 5.2.3 shows that on routine domestic problems, decision-making pattern is 51 per cent by husbands, 12 per cent by self only, 11 per cent by significant other and 27 per cent mutually. Similarly, on economic issues and child upbringing per cent of decision taken by adopters husband is 53 per cent. Further the decision on the issue of personal health and hygiene is either tackled individually by adopters (31 per cent) or mutually (36 per cent), only in 23 per cent and 11 per cent cases such decisions are taken exclusively by husbands and significant others respectively. Further, higher figures of mutual decision-making are on issues of small family (53 per cent) and limiting

family size (52 per cent). It may also be noted that out of only 18 significant others of adopters 16 (89 per cent) became active decision makers on the issue of limiting family size while on other issues significant others do not figure more than 9 (50 per cent).

Table 5.2.3: Family Issues and Intra house power dynamics among Adopters

Family Issues	Decision making				Total
	Self only	Husband	Significant Other	Mutually	
1. Routine domestic problems	9 (12%)	38 (51%)	8 (11%)	20 (27%)	75 (100%)
2.Economic issues	11 (15%)	40 (53%)	9 (12%)	15 (20%)	75 (100%)
3. Child upbringing	13 (17%)	40 (53%)	6 (8%)	16 (21%)	75 (100%)
4. Personal Health & Hygiene	23 (31%)	17 (23%)	8 (11%)	27 (36%)	75 (100%)
5. Idea of having small family	11 (15%)	16 (21%)	8 (11%)	40 (53%)	75 (100%)
6. Limiting Family size	5 (7%)	15 (20%)	16 (21%)	39 (52%)	75 (100%)

Source: Survey data

Thus, it may be noted that irrespective of communication domain and joint discussions among couples, the other family members matter while it comes to taking action for limiting family size. This fact of familial dynamics beyond 'couple' has to be kept in mind when issue of limiting family size is under consideration. Notwithstanding this, higher discussion with husband and significant others instead of self only facilitate this process of final decision making in positive direction.

Similarly, among non-adopters also the decision-making seems to be more either mutually or by husbands (table 5.2.4). However, with regard to issue of personal health and hygiene, 61 per cent non-adopters themselves take decision (against 31 per cent adopters) and only 4 per cent mutually decide (against 36 per cent adopters). On the issue of small family and family

limitation, many have planned/decided to limit family and undergo sterilisation while others are yet to decide but they are clear about who will matter and take final decision.

Table 5.2.4: Family Issues and Intra house power dynamics among Non Adopters

Family Issues	Decision making				Total
	Self only	Husband	Significant Other	Mutually	
1. Routine domestic problems	9 (12%)	33 (44%)	13 (17%)	20 (27%)	75 (100%)
2. Economic issues	8 (11%)	39 (52%)	10 (13%)	18 (24%)	75 (100%)
3. Child upbringing	15 (20%)	32 (43%)	9 (12%)	19 (25%)	75 (100%)
4. Personal Health & Hygiene	46 (61%)	22 (29%)	4 (5%)	3 (4%)	75 (100%)
5. Idea of having small family	10 (13%)	24 (32%)	11 (15%)	30 (40%)	75 (100%)
6. Limiting Family size	10 (13%)	23 (31%)	13 (17%)	29 (39%)	75 (100%)

Source: Survey data

For example on issue of small family to 40 per cent it will be mutually decided (against 53 per cent adopters), for 32 per cent by husbands, for another 15 per cent by significant others and 13 per cent are bold enough to decide by themselves only. Similar is the response on limiting family (in future), 39 per cent believe in mutual decision (against 52 per cent adopters), 31 per cent said their husband will decide while 17 per cent argued for significant others and 13 per cent said they themselves will decide. Thus, it clear from both tables that unlike general issue like domestic problems, economic problems and even child upbringing, the intimate issues like personal health and hygiene, and the issues of small family and family limitation differs in decision making matters and these dynamics have to be considered in any mobilization for small family norm or adoption of family planning. In order to have further clarity on the issue of communication domains and dynamics of decision making a focus

group discussion was conducted and the summary of the same is presented here.

The aforesaid FGD (refer **FGD-4**) was organised with a group of 10 women both adopters and non-adopters to understand how the intra-house dynamics of communication and power relations swing with regard to specific family issues. Group in general argued that they mutually discussed the issues with their spouses, and also with significant others. Group negated that there are barriers in discussing issues like domestic problems, economic issues and child upbringing. However, issue like personal health and hygiene is not much discussed and is brought to family notice only when some serious problem arises. Further, on issues like idea of small family and limiting family size, the discussions surfaced only after couples hard two-three children. The group logically argued that only after the birth of 2-3 children couples becomes conscious of their upbringing and their family conditions for the same. They further argued that on such issues mothers are more conscious and they initiate such discussions with their spouses by relating and reminding of others in community. In discussions many women lamented that only one of their child is in private school while rest are in government school, which they argued do not provide good education. Adopters also lamented why they have not early gone for sterilisation. However, they argue that much depends on decisions of their spouses and significant others. They argued that since husbands are main earners wives are to depend on them and that's the reason, why spouses and significant others prevails in final decision-making. However, in these discussions, the adopters and women with outside paid employment were

quite bold enough to argue that 'why shouldn't we take decision'. They also argued that ultimately every thing comes to be bore by them, be it child upbringing or managing the family. Spouses simply give money and forget the other problems. In general group seems to be self motivated and opined for more participatory/joint decision-making in their families. Probably, their economic constraints have made them bold enough to plead their own case.

These facts also negate the neo-Malthusian arguments that poor decision-making, lack of communication and low consciousness about family size and its limitation exist among poor. Our results from tables 5.1.1-5.2.4, focus group discussions (FGD-4) and case studies (CSN 7-8) argue just contrary.

CHAPTER-6

PROCESS OF CONTRACEPTIVE ADOPTION

CHAPTER-6

Process of Contraceptive Adoption

The methods to prevent births include, of course, all the methods of conception control and in addition, abortion- the prevention of birth even if conception has occurred.[1] Ironically, rather interestingly, a good amount of demographic literature is replete with observation of 'an inverse relation between certain attributes of modernity and family size'[2] and the 'rural couple is portrayed as having little control over the conditions of their lives and are governed in matters of fertility more by impulses than by rationality. Their fertility follows an unhindered course, without any conscious intervention on their part'[3]. Still others argued that 'in India high fertility is a reflection of copulation being only means of recreation among rural people. There is

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[1] Hauser, "On Non-Family Planning Methods of Population Control.", p. 353.

[2] W. Thompson, "Population," *American Journal of Sociology* 34 (1929)., F.W. Notestein, "Population: The Long View," in *Food for the World*, ed. T.W. Shultz (Chicago: University of Chicago Press, 1945)., A.J. Coale and E. M. Hoover, *Population Growth and Economic Development in Low Income Countries* (Princeton: Princeton University Press, 1958)., S.S. Leiberman, "Rural Development and Fertility Transition in South Asia: A Case for Broad Based Strategy," *Social Research* 47, no. 2 (1980)., Srinivasan, "Modernisation and Fertility Change: A Review of Theoretical Developments."

[3] F. Lorimer, *Culture and Human Fertility: A Study of the Realtion of Culture Conditions to Fertility in Non Industrial and Transitional Societies* (Paris: Unesco, 1954)., N. Howell, *Demography of the Dobe! Kung* (Cambridge, Mass.: Harvard University, 1979)., C. Wilson, "Natural Fertility in Pre-Industrial England, 1600-1799," *Population Studies* 38 (1984).

nothing except to go bed after dark.'[4] Patel lambasted on these studies and observed that:

> These studies betray a skin-deep understanding of the reality of fertility behaviour (which) becomes clear as soon as an attempt is made to take into account the sleeping patterns and leisure activities in traditional societies. These studies ignore the immense richness of local institutions of entertainment, recreation, relaxation, fun, merry-making and gossiping, not to mention well-developed folk arts, music and songs. These aspects of rural life can be known only through an in-depth knowledge of people's life styles and worldview. Unlike modern, industrial societies, the insulation of 'labour' from 'leisure' has not yet come about in rural societies like Mogra. Labour and leisure overlap here. Recreation, fun and frolic are knit into the working of society. In addition, there are several festive occasions when leisure predominates labour [parenthesis addition mine].[5]

She further noted that 'people in Mogra practice fertility control albeit through elaborate customs. Reproduction is not left entirely to the caprices of natural impulses. The fecundity duration is not fully realized in actual behaviour. *Fertility is brought to an end much before the end of the fecundity period* [italics mine].'[6] She lamented that a few demographic studies have recognized the prevalence of fertility controls in primitive/traditional societies.[7] She also

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[4] Enke, "The Economic Aspects of Slowing Population Grwoth.", U.N., "Concise Report of the World Population Situation in 1970-75.", Endres, *On Defusing the Population Bomb.*, S. George, *How the Other Half Dies* (Harmondsworth: Penguin, 1976).

[5] Patel, *Fertility Behaviour.*, p. 163.

[6] Ibid., p. 183.

[7] Ibid., p. 164. See A.M. Carr-Saunders, *The Population Problem: A Study in Human Evolution* (Oxford: Claredon Press, 1922)., D.M. Heer, "Fertility Differentials between Indian

noted that 'the fertility career is marked by a socially prescribed beginning and an end'[8] and even crystallised the fertility practices which 'prescribe and proscribe procreation'[9] and argued that 'giving up procreation usually results from a combination of three factors- one, achieving the socially optimum number and sex proportion of children; second, advancing in age; and third, attaining the status of a mother-in-law as a consequence of her son's or daughter's marriage'[10] and even devoted on the same theme two chapters of her book, one *indigenous modes of fertility control* and second on *modern fertility control.* Raina[11] in 1970 reviewed the follow up studies on contraceptive adoption in India. In case of intra-uterine contraceptive device (IUCD/IUD) on an average the acceptors had four children and median age at the time of first insertion was between 25 and 29 years. One IUCD insertion is estimated to prevent 0.5 birth. The median for men undergoing vasectomy was 35 to 39 years and that of tubectomy cases 31 years. The mean number of children in both cases was about five. A single sterilisation operation is

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and Spanish Speaking Parts of Andean Countries," *Population Studies* 18, no. 1 (1964)., M. Freebeme, "Birth Control in China," *Population Studies* 18, no. 1 (1964)., M. Douglas, "Population Control in Primitive Groups," *British Journal of Sociology* 17 (1966)., T.C. Smith, *Nakahara: Family Planning and Population in a Japanese Village, 1717-1830* (Stanford: Stanford University Press, 1977).,

[8] Patel, *Fertility Behaviour.*, p. 193.

[9] The proscription on procreation is at both levels i.e. onset and end of reproductive career. For example in Mogra (Patel study village) the first child is postponed by norms maintaining a time gap between *muklāwo* and childbirth. Usually the prescribed duration of such an interval is at least two years (p. 174). Similarly, social practices prohibit childbirth after a couple's married children enter their fertility careers (p. 184). See Ibid., p. 174, 184.

[10] Ibid., p. 165. The pregnancy of old mother or mother-in-law is subject of fun and humour. They are criticized for being over-indulgent in their sexual relations at an age when most older couples relinquish it. If an old couple continues engage in sex even without any bearing on contraception, it provokes a lot of gossip and latent derision, p. 166. For more on pregnant grand mother complex, see C. Chandrasekharan, "Cultural Emphasis in the Mysore Population Study," in *Fertility and Mortality*, ed. K. Mahadevan (New Delhi: Sage, 1986)., Caldwell and Caldwell, "The Role of Marital Sexual Abstinence in Determining Fertility: A Study of the Yoruba in Nigeria.", J.C. Caldwell, *Theory of Fertility Decline* (London: Academic Press, 1982).

[11] Raina, "Reseach in Family Planning.", pp. 301-302.

estimated to prevent 1.6 births. Pathak and Singh[12] analysis for the period 1972-91 shows that the average fecundability level of women has also gone down over the period due to contraceptive use, and more recently, the same is also supported by Visaria and Visaria. The NFHS (read NFHS-1), conducted in 1992-93 in the twenty-five states with a representative sample of 90000 women has reported that 'almost 96 per cent of the respondents knew about a method of contraception, particularly female sterilisation. About 41 per cent of the respondent women used a contraceptive method; nearly 89 per cent of them used a 'modern' method. Almost 85 per cent of the users of modern contraceptive method had adopted female or male sterilisation. Only 5.5 per cent of them have used reversible methods such as pills, IUD, or condoms; their percentage was almost 12 in urban areas but only 3 in rural areas. This difference contributed to correspondingly higher contraceptives use rate of 51 per cent in urban areas, compared to 37 per cent in rural areas.'[13] The second National Family Health Survey that is NFHS-2[14] data show that nationally, nearly one half of currently married women (48 per cent) were using some methods of contraception in 1998-99. The female and male sterilisation together account for 84 per cent of current contraceptive prevalence due to modern methods, and is 75 per cent of overall contraceptive prevalence. Officially sponsored spacing methods (oral contraceptive pills, intra-uterine device (IUD) and condoms) account for 14 per cent of current contraceptive use. The use of traditional contraceptive methods is reportedly low, accounting

[12] Pathak and Singh, "Fertility Transition in India.", p. 184., Also see Visaria and Visaria, "India's Population.", p. 72.

[13] International Institute for Population Sciences., *National Family Health Survey (Mch and Family Planning) India, 1992-93*. Cited in Visaria and Visaria, "India's Population.", p. 72.

[14] International Institute for Population Sciences. and ORC Macro., *National Family Health Survey (Nfhs-2), 1998-99*. Cited in Santha, "Contraceptive Use Dynamics.", pp. 26-29.

for 10 per cent of the current contraceptive use in the country. NFHS-2 also notes that despite improved availability and access to contraceptive services, a substantial proportion of pregnancies (21 per cent of all pregnancies that resulted in live birth nationally) were unplanned (mistimed or unwanted). It also reports that 16 per cent of currently married women have an unmet contraceptive need, which translates into one-fourth of women who wish to space or limit births. Access to contraceptive methods has increased significantly, and only a negligible minority of women (4 per cent as per NFHS-2) perceive availability, accessibility or cost as major impediment to using contraception. NFHS-2 also noted that three in four sterilisation users and two in five users of other modern methods received follow up services. On this point Santha[15] rightly noted that in practice, access to and availability of services are significant issues of concern. She further notes it is now widely acknowledge that quality of family planning services is generally poor. Service providers tend to be insensitive and disregard women's need for privacy. Pre-acceptance counselling or check-ups are limited, and little attention is paid to poor-acceptance follow-up services.[16] It is being noted that as contraceptive use increases and becomes a more established behaviour, prevalence is no longer a sufficient index of programme success.[17] Contraceptive continuation may become more important than acceptance in increasing contraceptive prevalence.[18] These observations are very apt in the

[15] Santha, "Contraceptive Use Dynamics.", p. 36.

[16] Ibid., p. 39.

[17] Shireen J. Jejeebhoy, "Measuring Contraceptive Use and Continuation: An Overview of New Approaches" (paper presented at the In measuring the dynamics of contraceptive use: Proccedings of the United Nations Expert Group Meeting, New York, 1990).

[18] A.K. Jain, "Fertility Reduction and the Quality of Family Planning Services," *Studies in Family Planning* 20, no. 1 (1989).

light of inconsistency between the increase in CPR and corresponding decline in TRF. For example Pathak and Singh[19] observed:

> In the decade of the 1980s the CPR almost doubled. Compared to the increase in the CPR, the TFR has declined only marginally. The TFR declined from 4.5 in 1981 to below 3.6 in 1991, a decline of 0.9 in 10 years and after doubling the CPR and rise in the mean female age at marriage from the level of 18 in 1980 to 19 in 1990. In Kerala and Tamil Nadu, there is some consistency in the change in the CPR and fertility. These are the two states, where the programme has attracted comparatively more younger couples. The spacing method is adopted even by the women with less than two children. The states like Haryana, Maharastra and Punjab which have a very popular programme of spacing method have not achieved the expected decline in fertility. In these states spacing methods are adopted at much older ages and only after having three living children. It seems that even the spacing is adopted as a terminal method for "Wait and See" before switching over to the permanent method. The example of Haryana and Punjab is classic. In Haryana, the TFR is 4.0 with the CPR of 58 per cent. On the other hand, the TFR for Punjab is 3.1 with the CPR level of 74 per cent. Kerala and Tamil Nadu have now achieved an NRR of one with a CPR which is much below 60 per cent.

They concluded that our programme performance in terms of the acceptance rate or in terms of the increase in the CPR has been quite successful, but it had not got the desired impact on fertility. It is also observed in studies like that of Wyron and Gordon in Punjab, Kara and Sinha in Orissa and Patel in Rajasthan that people observe strictly the social norms of fertility behaviour. The

[19] Pathak and Singh, "Fertility Transition in India.", pp. 192-93.

contraceptives are accepted only as far as they dovetailed with norms.[20] Qualifying the same, Dandekar[21] noted that the attitude towards family planning was more favourable among couples with three to five children in the six rural communities she studied in India. A closely related aspect of family planning is 'the impact of contraceptives on the health of the individual users.'[22] The WHO[23] expert group has classified these side effects into two groups- (a) rare experiences or complications of a serious and at times fatal character and (b) common effects that have only a minor adverse effect on health or may even be beneficial. On this issue Rao observed, 'at any rate in developing countries where maternal mortality rates are relatively high, risk from use of birth control methods is far less significant than risks associated with pregnancy or mortality and morbidity resulting from illegally induced abortions.'[24]

6.1 Contraceptive Information- timing and sources

Knowledge of contraception is a pre-requisite of fertility reduction, but knowledge alone is not enough to stimulate action.[25] In terms of contraceptive

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[20] Wyon and Gordon, *The Khanna Study : Population Problems in the Rural Punjab.*, P.K. Kara and B.N. Sinha, "Family Welfare Programme and Its Evaluation: Implications and Recommendations," in *Population, Family and Culture*, ed. R.N. Pati (New Delhi: Ashish Publishing Corp., 1987)., Patel, *Fertility Behaviour.*, pp. 199-200.

[21] K. Dandekar, *Demographic Survey of Six Rural Communities* (Bombay: Asia Publishing House, 1959).

[22] A good many social workers in their quest to outline the role of social workers in family planning have stressed on this aspect. See Gore, "Key Note Address.", Rappaport, "Education and Training of Social Workers for Roles and Functions in Family Planning."

[23] WHO, "Technical Report Series No. 442," (Geneva: World Health Organisation, 1970).

[24] Rao, "Health and Educational Approach to Family Planning-a Review of Studies and Implications for Social Worker's Education.", p. 26.

[25] Charles A. Kiesler and Others, *Attitude Change: A Critical Analysis of Theoretical Approaches*, vol. I (New York: John Wiley & Sons, 1969).

knowledge female respondents in Khan's study[26] more frequently mentioned condom (66 per cent) and loop (53 per cent). A relatively smaller proportion of females mentioned vasectomy (41 per cent) and tubectomy (20 per cent). It is also observed that female with a large number of children (four or more) or higher education had a clear idea of the places where, family planning facilities were available. As her family size increases, a woman becomes sensitised to the need for contraception and tends to gather more information about it.[27] The study further shows that in the case of female respondents the single major source of information (58.7 per cent) was their husbands followed by doctor/lady doctor (11.0 per cent), ANM and other family planning workers (11.0 per cent) and friends (10.1 per cent).[28] Patel observed that 'the people of Mogra became familiar with it (family planning programme) during the national emergency' and 'to most people in Mogra, FPP is synonymous with termination of fertility i.e. sterilisation'.[29] However, such a perception is typical of the trend prevalent in most developing societies, particularly in the Asian region.[30]

Any attempt to understand the 'dynamic' process of contraceptive adoption cannot ignore the discussion on the level of contraceptive information among the clients, rather it is the first step to understand the same. The tables 6.1.1 shows the awareness of adopters about contraceptive methods, it specify how

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[26] Khan, *Family Planning among Muslims in India.*, p. 130, 134.

[27] Ibid., p. 148.

[28] Ibid., p. 170.

[29] Patel, *Fertility Behaviour.*, p. 185, 186.

[30] U.N., "Variations in the Incidence of Knowledge and Use of Contraception: A Comparative Analysis of World Fertility Survey Results of Twenty Developing Countries`," (New York: United Nations, 1981).

many of adopters have just heard about any contraceptive, when they first heard about it and what are the sources. Their actual understanding and technical know-how of specific contraceptive devices are later explored with the help of FGDs and case studies. It is clear from the table 6.1.1 that cent per cent of the adopters heard of sterilisation (they should as they have already undergone sterilisation) while only 64 out of 75 adopters (85 per cent) heard of pills followed by 63 (84 per cent) who heard of condoms, while those who have heard of IUD, injectables and traditional methods are 44 (59 per cent), 38 (51 per cent) and 26 (35 per cent) respectively. Thus, minus sterilisation, pills and Condoms, a good percentage of adopters (65-41 per cent) have not even heard of specific contraceptive devices.

Table 6.1.1: Adopters Timing when first heard of Family Planning Devices

Family Planning Devices	Adopters				
	Before Marriage	After marriage to II child birth	III to V child	VI and more	Total
1. Condoms	1 (2%)	37 (59%)	23 (37%)	2 (3%)	63 (100%)
2. Pills	2 (3%)	38 (59%)	21 (33%)	3 (5%)	64 (100%)
3. IUD (Cu-T)	5 (11%)	23 (52%)	12 (27%)	4 (9%)	44 (100%)
4. Injectables	1 (3%)	15 (39%)	19 (50%)	3 (8%)	38 (100%)
5. Sterilisation	22 (29%)	30 (40%)	17 (23%)	6 (8%)	75 (100%)
6. Traditional methods	0 (0%)	4 (15%)	19 (73%)	3 (12%)	26 (100%)

Source: Survey data

However, among those who have heard of specific contraceptive methods, the table 6.1.1 shows that in case of condoms 59 per cent heard after marriage and second childbirth, followed by 37 per cent after third to fifth childbirth. Likewise out of those who heard of pills, IUD, injectables and traditional methods majority 92, 79, 89 and 88 per cent respectively heard during the period after marriage to fifth childbirth. Only in case of sterilisation 29 per

cent heard before marriage otherwise during this period the percentage of knowing about other contraceptives is negligible and varies from 11 per cent about IUD, to 3 per cent for pills, 2 per cent for condoms and zero per cent for traditional methods. The discussions with key informants and informal discussion in community clearly showed the proscriptions on knowing about contraceptives before marriage. In terms of sources (table 6.1.2) from where adopters heard of any contraceptive, the major source is peers ranging from 32 per cent for condoms, followed by 39 per cent for pills, 48 per cent for IUD, 58 per cent for injectables, 31 per cent for sterilisation and 81 per cent for traditional methods. The mass media contribution is relatively more for sterilisation (21 per cent), followed by condoms (14 per cent) and pills (13 per cent). The significant others as a source have more contribution regarding pills and sterilisation that is 22 per cent and 24 per cent respectively. The contribution of government health workers in spreading awareness is 25 per cent for IUD, 21 per cent for condoms, 14 per cent for pills, 13 per cent for injectables and 12 per cent for sterilisation.

Table 6.1.2: Adopters across Sources from where first heard of Family Planning Devices

Family Planning Devices	Adopters							
	Govt. Health Worker	Voluntary Health worker	Mass media	Local IEC activities	Husband	Significant Other	Peers	Total
1. Condoms	13 (21%)	1 (2%)	9 (14%)	6 (10%)	5 (8%)	9 (14%)	20 (32%)	63 (100%)
2. Pills	9 (14%)	1 (2%)	8 (13%)	6 (9%)	1(2%)	14 (22%)	25(39%)	64 (100%)
3. IUD (Cu-T)	11 (25%)	1 (2%)	3 (7%)	3 (7%)	0 (0%)	5 (11%)	21(48%)	44 (100%)
4. Injectables	5 (13%)	1(3%)	3 (8%)	1 (3%)	2 (5%)	4 (11%)	22 (58%)	38 (100%)
5. Sterilisation	9 (12%)	0 (0%)	16 (21%)	6 (8%)	3 (4%)	18 (24%)	23 (31%)	75 (100%)
6. Traditional methods	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	5 (19%)	21 (81%)	26 (100%)

Source: Survey data

Non-adopters also have similar pattern with relatively less awareness than adopters. Here of total non-adopters just 70 out 75 (i.e. 93%) heard of sterilisation for which there is always hue and cry (table 6.1.3). Similarly, for other contraceptives, the non-adopters percentages of hearing about specific contraceptives are 83 per cent each for pills and condoms, followed by 51 per cent for IUD, 45 per cent about injectables and only 25 per cent heard of traditional methods. The table 6.1.3 also shows that the number and percentage of the timings when non-adopters first heard of contraceptives (out of those who have heard about specific device).

Table 6.1.3: Non Adopters Timing when first heard of Family Planning Devices

Family Planning Devices	Non Adopters				
	Before Marriage	After marriage to II child birth	III to V child	VI and more	Total
1. Condoms	6 (10%)	36 (58%)	19 (31%)	1 (2%)	62(100%)
2. Pills	5 (8%)	30 (48%)	26 (42%)	1 (2%)	62 (100%)
3. IUD (Cu-T)	3 (8%)	21 (55%)	14 (37%)	0 (0%)	38 (100%)
4. Injectables	1(3%)	18 (53%)	15 (44%)	0 (0%)	34 (100%)
5. Sterilisation	25 (36%)	27(39%)	18 (26%)	0 (0%)	70 (100%)
6. Traditional methods	0 (0%)	4 (21%)	15 (79%)	0 (0%)	19 (100%)

Source: Survey data

Here also majority heard during the period after marriage to second childbirth. For example, 58 per cent heard of condoms after marriage and second childbirth, and during the same period, 55 per cent heard of IUD, followed by 53 per cent about injectables, 48 per cent about pills, 39 per cent about sterilisation and 21 per cent about traditional methods. Like adopters, majority among non-adopters, 79 per cent of those who have heard of traditional methods, heard it after third to fifth childbirth. However, it may be noted that irrespective of number of non-adopters who heard of contraceptives, their

percentage in before marriage group is more than adopters. This shows the increasing awareness of contraceptive at more early ages among younger generations, as adopters are relatively older than non-adopters. Particularly, with regard to temporary methods like condoms and pills non-adopters who heard before marriage are 10 per cent and 8 per cent (against 2 per cent and 3 per cent of adopters) respectively.

The table 6.1.4 shows the sources from where non-adopters heard of specific contraceptive devices. Like adopters, most of the non-adopters also heard from their peer groups.

Table 6.1.4: Non Adopters Sources from where first heard of Family Planning Devices

Family Planning Devices	Non Adopters							
	Govt. Health Worker	Voluntary Health worker	Mass media	Local IEC activities	Husband	Significant Other	Peers	Total
1. Condoms	11(18%)	0 (0%)	7 (11%)	7 (11%)	11 (18%)	6 (10%)	20 (32%)	62 (100%)
2. Pills	10 (16%)	1 (2%)	9 (15%)	9 (15%)	6 (10%)	4 (6%)	23 (37%)	62(100%)
3. IUD (Cu-T)	4(11%)	0 (0%)	4 (11%)	3 (8%)	2 (5%)	7 (18%)	18 (47%)	38(100%)
4. Injectables	5 (15%)	1 (3%)	2 (6%)	3 (9%)	4 (12%)	2 (6%)	17 (50%)	34(100%)
5. Sterilisation	7 (10%)	0 (0%)	22 (31%)	10 (14%)	0(0%)	11 (16%)	20 (29%)	70(100%)
6. Traditional methods	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	3 (16%)	16 (84%)	19(100%)

Source: Survey data

The table 6.1.4 shows that among those who heard of condoms, 32 per cent heard about it from peers and likewise for pills, IUD, injectables, sterilisation and traditional methods, the percentages are 37 per cent, 47 per cent, 50 per cent, 29 per cent and 84 per cent respectively. The mass media has major role in promoting awareness about sterilisation, as 31 per cent heard about sterilisation from mass media. With regard to government health worker, the percentages for hearing from government health worker are 18 per cent in case of condoms, 16 per cent for pills, 15 per cent for injectables, 11 per cent for

IUD and 10 per cent for sterilisation. In terms of significant others as source for contraceptive information, in case of non-adopters it is less and ranged from 6-18 per cent while among adopters the range is 11-24 per cent. This again reflects the wider communication domains among adopters than non-adopters.

Thus the tables 6.1.1-6.1.4 make it clear that in comparison to mass campaigns for spreading awareness of contraceptives, the percentage of simply hearing about contraceptives is low. Even in case of sterilisation among non-adopters percentage was not cent per cent. However, it did come out that major source for such information are peer groups and this reflects the importance of 'peer groups' in spreading contraceptive information and its technical know-how. It may not be out of context to say that there is a need to focus on this group and use the concept of 'peer animators' to promote the virtues of contraceptives at an early stage which will not only substantially contribute to reducing TFR but also enable the couples to enjoy their marital life without the fear of pregnancy and childbirth. There is a need of capacity building with regard to contraceptive know-how of this group and to promote them as 'peer/community educators/animators'. More recently under NRHM, Government of India has initiated the concept of Health Activist (ASHA) who is to be identified, trained and paid on incentive basis for linking the target masses to reproductive and child health services especially at sub-centre level. The population coverage per ASHA is 1000 people. However, limited experiences with ASHA, AWW and ANM show that ASHA has become more

an assistant to permanent government health workers than a health activist, as envisioned in the concept of ASHA.

6.2 *Dynamics of contraceptive adoption- discussions and decisions*

Marshall[31] in his study of North Indian village noted that behaviour is determined by phenomena of experience rather than by external objective, physically described reality. Elsewhere it is observed that a perception of the consequences of birth control plays a very important role in the acceptance or rejection of contraceptives.[32] Khan[33] aptly summed that the probability of resorting to any action (i.e. acceptance of family planning) will vary directly with the strength of expectancy that the action will lead to given consequences (e.g. a better standard of living, better education for children etc.) and value of these consequences to the individual. In Khan's study[34], when respondents were asked 'who is responsible for family planning?' 95 per cent of the female respondents felt that it was the husband's responsibility and he should take the initiative. In contrast, about 87 per cent of male respondents said that the husband and wife were equally responsible. Further the attitude towards family planning of important and elder people like in laws and close relations, sometimes, also works as a barrier to family planning acceptance. A number

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[31] J.F. Marshall, "A Conceptual Framework for Viewing Responses to Family Planning Programs," *Journal of Cross-Cultural Psychology* 3, no. 1 (1972).

[32] T.J. Crawford, "Family Planning Attitude and Behaviour as a Function of the Perceived Consequences of Family Planning," in *Further Research in Family Planning*, ed. D.J. Bouge (Chicago: University of Chicago, 1970). Cited in Khan, *Family Planning among Muslims in India.*, p. 10.

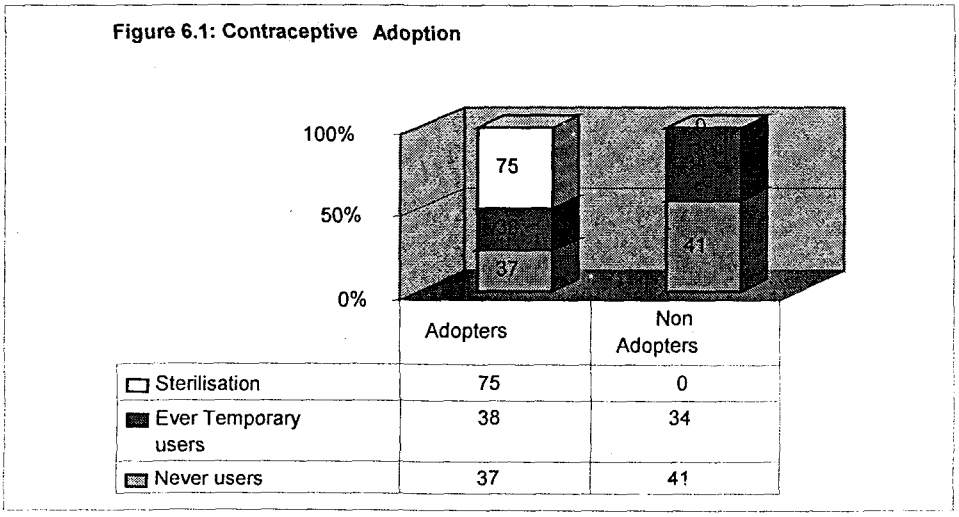
[33] Khan, *Family Planning among Muslims in India.*, pp. 10-11.

[34] Ibid., pp. 174-175.

of female respondents reported the opposition of their in laws as being responsible for their not adopting family planning.

This sub-chapter explores the dynamics of contraceptive adoption- how the responses both at personal (self) and familial (husband and significant other) levels varies in the adoption of contraceptives. Further the responses not only varies across personal and familial levels but shifts in respect to modern temporary contraception and permanent contraception like sterilisation. Before dwelling on typology of responses, it should also be noted once again that of the total sample, 75 are adopters (sterilisation) and 75 are non-adopters, further among adopters, 38 (51 per cent) are ever temporary contraceptive users while among non-adopters, the ever-temporary users are 34 (45 per cent) (**Figure 6.1**). Thus, among adopters the percentage of ever-temporary users is more than non-adopters (at the margin of 6 per cent).

Figure 6.1: Contraceptive Adoption



In order to quantify the personal and familial responses on contraceptive adoption four typologies are chosen viz.– encouragement, simple consent, indifference and outright rejection. The table 6.2.1 shows the personal and familial responses on ever-temporary contraceptive adoption. In aggregate, there are 22 per cent responses of encouragement, 69 per cent of simple consent, followed by 9 per cent with response of indifference.

Table 6.2.1: Adopters personal and familial response on Ever Temporary contraception

Typology of response	Personal	Familial		Total
	Self	Husband	Significant Other	
Encouragement	16 (42%)	2 (5%)	1 (10%)	19 (22%)
Simple consent	21 (55%)	33 (87%)	5 (50%)	59 (69%)
Indifference	1 (3%)	3 (8%)	4 (40%)	8 (9%)
Total	38(100%)	38 (100%)	10 (100%)	86 (100%)

Source: Survey data

In terms of personal responses (adopters themselves) the above table 6.2.1 also shows that 42 per cent adopters themselves response is that of encouragement, followed by 55 per cent with simple consent response and 3 per cent showed indifference. In case of their spouses, the majority 87 per cent gave simple consent followed by 8 per cent with response of indifference and only 5 per cent showed encouragement. Further, 10 of these ever-temporary contraceptive users live in joint family and most of significant others have their responses either of simple consent (50 per cent) or of indifference (40 per cent). It may also be noted that the encouragement responses for temporary contraception is more at personal level (42 per cent) then at familial level (husbands 5 per cent and significant others 10 per cent).

Among non-adopters, as tables 6.2.2 informs that an aggregate of 55 per cent have simple consent responses followed by 38 per cent with encouragement and in 7 per cent case indifference is the response. Coming to non-adopters themselves, they have 53 per cent responses of encouragement, followed by 41 per cent of simple consent and 6 per cent of indifference. The response of spouses is better among non-adopters, as 29 per cent of them (unlike 5 per cent in case of adopters) gave encouragement while 65 per cent showed simple consent. With regard to significant others, out 20 non-adopters who lives in joint families only 8 are temporary contraceptive users and 75 per cent of their significant others gave simple consent response. Further, the personal response is more positive than familial as 'encouragement' response is 53 per cent for non-adopter themselves and 29 per cent for spouses (whose major response is simple consent i.e. 65 per cent) and 13 per cent for significant (whose major response is again of simple consent i.e. 75 per cent).

Table 6.2.2: Non Adopters personal and familial response on Ever Temporary contraception

Typology of response	Personal	Familial		Total
	Self	Husband	Significant Other	
Encouragement	18 (53%)	10 (29%)	1 (13%)	29 (38%)
Simple consent	14 (41%)	22 (65%)	6 (75%)	42 (55%)
Indifference	2(6%)	2 (6%)	1 (13%)	5 (7%)
Total	34 (100%)	34(100%)	8(100%)	76 (100%)

Source: Survey data

Here it may be noted that these are intimate and taboo matters but fertility behaviour and its regulation is also equally important and of concern to family, that's why directly or indirectly, explicitly or implicitly the matters reach to significant others who respond accordingly and their communication

again directly or indirectly reach the couples. It is worth important to note that women (both adopters and non-adopters) have high percentages for encouragement than their husbands and significant others. This shows that woman in major of cases take initiatives for contraception as she is first to become conscious of its need owing to pregnancy burden, child care and also managing the household problems. It may also be noted (later FGDs will clear elaborate) that although majority of sampled women are housewives and their husbands are main earners but it is woman who is to face the constraints while managing the household out of limited income. Further, it is encouraging to see that among both adopters and non-adopters, there is no response of 'rejection' either by women themselves or their spouses and significant others and this variable got zero value and hence dropped from tabulation. This fact, from this small sample, further ascertains the scope and acceptability of temporary contraception provided they are given with proper counselling and clarification. The field experiences rather shows that there is high unmet need for temporary contraception, respondents remarked on the improper supply of temporary contraceptive methods which they argued are much needed in the community. This again reflects the empty slogans at the surface level. The table 6.2.3 shows responses on adoption of sterilisation. It shows that in terms of aggregate responses on sterilisation, the simple consent has high value of 51 per cent followed by 27 per cent encouragement, 12 per cent for indifferences and more importantly in case of sterilisation, unlike temporary contraception, 10 per cent of responses are for rejection. Among adopters self response, 53 per cent simply gave consent while 43 per cent played the leading role

(encouragement), 3 per cent have indifference and even one adopter response was that of rejection (her case study later).

Table 6.2.3: Personal familial response on adoption of Sterilisation

Typology of response	Personal	Familial		Total
	Self	Husband	Significant Other	
Encouragement	32 (43%)	9 (12%)	5 (28%)	46 (27%)
Simple consent	40 (53%)	40 (53%)	6 (33%)	86 (51%)
Indifference	2 (3%)	16 (21%)	2 (11%)	20 (12%)
Rejection	1 (1%)	10 (13%)	5 (28%)	16 (10%)
Total	75 (100%)	75 (100%)	18 (100%)	168 (100%)

Source: Survey data

With regard to their spouses the table 6.2.3 further shows that 53 per cent gave simple consent, 21 per cent showed indifference followed by 12 per cent with encouragement response and almost equally 13 per cent rejected the same. Further, significant others responses shift more towards encouragement and rejection unlike their response in case of temporary adoption. The 28 per cent of significant others gave encouragement, followed by equal per cent of those who rejected the idea and another 33 per cent showed indifference while 11 per cent gave simple consent.

In order to make the picture clear let's see how the decision making proceeds with these initial responses on sharing the idea of adopting contraceptives. The table 6.2.4 and 6.2.5 show the process of decision making in temporary contraceptive adopters and non-adopters. In case of condom usage among adopters, 81 per cent jointly decided with husband (unlike 76 per cent in case of non adopters, table 6.2.5) while 19 per cent did not have any say (against 24 per cent among non-adopters) in condom usage by their husbands. In the adoption of condoms, there was not participation of significant others and

neither the respondents themselves decided which they can't as it is male centric. The situation changes in case of oral contraceptive pills where 76 per cent adopters (against 73 per cent in case of non adopters) decided jointly with their husband, 24 per cent decide the use in coordination with significant others, in case of non adopters the same is 9 per cent. Only among non-adopters, 2 per cent of the pills users have decided to use it by themselves (self only). There are only three cases of intra uterine contraceptive device (IUCD) users, one among adopters and two among non adopters and all decided to adopt the same by their self only decision.

Table 6.2.4: Ever Temporary Contraception and decision-making among Adopters

Family planning method/s Adopted	Participation in Decision Making				Total
	Jointly with Husband	Jointly with Significant Other	Self only	No say	
1. Condoms	13 (81%)	0 (0%)	0 (0%)	3 (19%)	16 (100%)
2. Pills	16 (76%)	5 (24%)	0 (0%)	0 (0%)	21 (100%)
3. IUD (Cu-T)	0 (0%)	0 (0%)	1 (100%)	0 (0%)	1 (100%)
Total	29 (76%)	5 (13%)	1 (3 %)	3 (8%)	38 (100%)

Source: Survey data

Table 6.2.5: Ever Temporary Contraception and decision-making among Non Adopters

Family planning method/s Adopted	Participation in Decision Making				Total
	Jointly with Husband	Jointly with Significant Other	Self only	No say	
1. Condoms	16 (76%)	0 (0%)	0 (0%)	5 (24%)	21 (100%)
2. Pills	8 (73%)	1 (9%)	2 (18%)	0 (0%)	11 (100%)
3. IUD (Cu-T)	0 (0%)	0 (0%)	2 (100%)	0 (0%)	2 (100%)
Total	24 (71%)	1 (3%)	4 (12%)	5 (15%)	34 (100%)

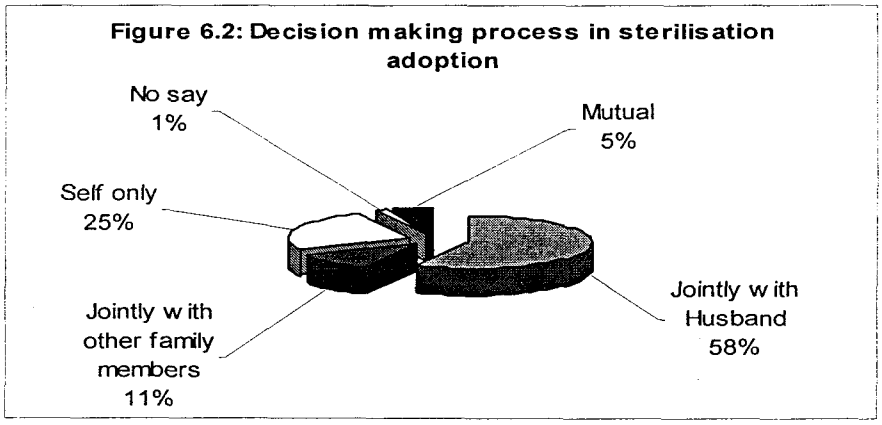
Source: Survey data

Thus overall the decision-making is quite participatory as both among adopters and non-adopters, 76 per cent and 71 per cent respectively took

decision jointly with their husbands in the usage of modern temporary contraceptives (tables 6.2.4 and 6.2.5).

In case of sterilisation the **figure 6.2** shows the decision making process. Here also 58 per cent decided jointly with husband, 11 per cent jointly with significant others. In sterilisation there are also extremes. For example 25 per cent took unilateral decision while in 5 per cent cases the decision making was highly participatory that is adopters, their husbands and significant others mutually decided to adopt sterilisation. In only one case, there was also no say of adopter while she undergoes sterilisation.

Figure 6.2: Decision making process in sterilisation



It may be noted that each of these figures have a long track debates while arriving at deciisons and these are further exacerbated with further pregnancy outcomes (which creeps in during the prolonged process of discussions and final decision) and then comes the final decision either unilaterally or jointly. The following case study (CSN-9) and FGDs (FGD-5 and FGD-6) will through light on the dynamic process of contraceptive adoption both temporary and permanent. Santosh Kumari (refer **CSN-9**) aged 28 and married

at the age of 18 years. She has undergone sterilisation at the age of 27 years with 5 children (3 males and 2 females) along with one stillbirth. Her case study became worth important as on dynamics of contraceptive adoption, she argued that she 'rejected' for undergoing sterilisation and she has no participation i.e. no say in undergoing sterilisation. We studied her to understand the subtle dynamics. Santosh Kumari is illiterate but works in a lock factory at city and earns 600 per month. Her husband also an illiterate and is an unskilled worker with earnings about Rs. 2000 per month and both lives in nuclear family. Santosh Kumari argued that she had much heard about the negative consequences of sterilisation and is thus fearful of it. Her husband argued given their our limited income and five children they were neither willing nor were in a position to afford any more children. Further, since they live in nuclear family she all alone has to manage children as well as work. He argued that she also did not want any more child but was very fearful of sterilisation unnecessarily (*bekār mein dartī thī*) and thus he took initiative and talked to ANM and along with her, couple went for sterilisation at District hospital. On being asked, Santosh Kumari now argued that she do not know why she was so afraid of and probably stories among peers made her so afraid. Now she said, her husband rightly and boldly compelled her for sterilisation. When we appreciated her husband, Shravan Singh, decision and told him that generally women took such decisions and husbands do not contribute. He very logically argued that all wants less children and even want to stop but somehow they are reluctant to speak because of cultural morales (*sab chahte hai, maryada mein bolte nahin hain*).

Thus, the process of family planning should include husbands as active promoters rather seeing them as passive supporter or antagonistic to family planning. Further, in order to understand the dynamics in the adoption of temporary contraceptive methods the focus group discussion (**FGD-5**) was organised with a group of 10 ever-temporary contraceptive users. The group argued that there is not much discussion on temporary contraceptive use and it just goes on. On further probing, it comes out that in case of condoms, husbands who brought it give at least first start and even many learned about it for the first time on the very same night. Thereafter, it is woman who looks for ANM/health workers to procure the same. In the discussion, they much lamented on the non-availability of this free supply and even argued that it not money but problems in purchasing from market. Their spouses brought it from market and sometimes they did, sometimes not and this results in irregular use of condoms. Group did spoke of hassles but also argued that there should be easy and regular availability. On the question of their joint participation in use of condoms, they rejected the question with argument that 'what else to do' (*aur kyā karen*). With regard to pills, it is women who procure it from ANM or health workers and in that it is their peer groups who facilitate them. The group members also argued that they shared their use with husbands and in laws (in case of joint family. Group on being asked for their familial responses told that on temporary contraception there are no outright rejections. The group also seemed without any inhibition in the use of temporary contraceptives, their only concern was improper supply of free contraceptives and hassles in purchase of contraceptives. In the group none was user of IUD, but they had many myths regarding IUD and also that for its insertion they

have to go PHC and, even argued that it better to go for sterilisation than for IUD. Thus, it can safely be inferred that temporary contraceptives can be easy promoted as there is high unmet need for these contraceptives. Moreover, with objective to understand the dynamics in the process of sterilisation adoption and how the final decision and action is sought after much delayed discussions with in the family, exacerbated further if family is joint in nature, a FGD (refer **FGD-6**) was organised with a group of 10 women who have undergone sterilisation. The group responded that after having 3-4 children, women start thinking of limiting family and since they either have bitter experiences or do not heard of temporary contraceptives and their failure, they thought of sterilisation as last resort. Initially, the wife shared their intension with husband, with background note on family income and children's future. Group argued that in most of the cases husbands turned it down by relating it to their poor health and fears of sterilisation. In being successful, if family is joint the discussion went to mother-in-law directly and to father-in-law indirectly through other old ladies in community or through mother-in-law if she is there. Group argued that in almost all families there is initial reluctance and much here now depends on women to pursue their husbands. Some even sought help of ANM in mobilizing their family members. Women themselves continue persuasion with citation of successful sterilisation cases of women in community, and husbands keep contradicting the same. The process goes on even for months and years depending upon the responses, sometimes it becomes the cause of conflict among couples. Major turning points are when woman finds that her periods did not returned and that there are chances of pregnancy. In such cases, normally husband's agreed, sometime women use it

as excuse. More prolonged discussions even result in pregnancy and many times women went for 'unsafe abortion' or for more safe abortion and sterilisation together at district hospital. Those who went for unsafe abortions become quite critical of their family and normally after one or two unsafe abortions they by themselves go for sterilisation without bothering about family and consequences. Others gave births to more children after which whole family decides for sterilisation. Thus, high parity sterilisation or sterilisation of 'exhausted generation' are not due to willingness to have same at high purity but due to delayed decisions in the family which puts the mother to either experience more pregnancies and childbirths or unsafe abortions. Group told that many times husbands starts using condoms and like but these did not works. Group also told of their spouses bringing capsules from medical stores (chemist shop) at rate of Rs. 50 and eight such capsules are to be taken to abort the pregnancy.

Many studies noted the gap between first consciousness of restricting family size and undergoing sterilisation. Visaria and others[35] in their overview of Abortion Assessment Project of India (AAP-I) studies across 6 states noted under heading 'female Sterilisation as first and final method of contraception' that women find the reversible or spacing methods of contraception inconvenient or unacceptable, and after giving birth to desired number of children, they opt for sterilisation. However, *since the desired family size is measured in terms of surviving children, typically couples wait for a few years*

[35] Visaria et al., "Abortion in India- Overview and Synthesis of Emerging Issues from the Qualitative Studies.", p. 7.

to ensure the survival of their children before accepting a permanent method of sterilisation.'

In backdrop of above FGDs and data collected and experiences therefrom, we agree partly with their contention but disagreed with the logic that it is the issue of child survival that they waits for few years rather, at least for sampled population, this 'wait' or we say 'delay' is due to delayed final decision for sterilisation which gets entangle in the intra-house discussions and decisions. The above discussion also justifies that if proper activating energy is provided to couples than there will be better and more potential users of family planning. But for this activation energy, a catalyst is needed, which unfortunately never boggles in the minds of our family planning/welfare department, which it seems only rely on 'targets for no targets'. It is here the students of social work can best perform their role as that of a catalyst.

6.3 First Ever Contraceptive usage: timing, experiences and switch over

In Khan's Kanpur study[36] less than two per cent of the respondents started using a contraceptive just after the marriage. It is argued that such a low percentage can be explained in the light of the existing norms of our society to have a child as soon as possible after marriage.

[36] Khan, *Family Planning among Muslims in India.*, pp. 168-169.

Stycos[37] in his Puerto Rican study, Poffenbberger[38] *et. al* in their study of an Indian village and Khan[39] in his urban Kanpur study found some psychological factors operating against the condom. In Stycos and Poffenberger studies males rejected the condom because they thought condoms were to be used only with prostitutes as a protection against venereal disease. The use of condom with the wife seems like degrading a pure and sacred relationship. Poffenberger also reported the feeling of the respondents that the use of a condom would deprive the female of the 'power of husband (i.e. semen)' and thereby make her weak. Khan further noted the major objection to condom, the most used method, is that it destroys the sexual pleasure. Out of those who gave up, 57 per cent did so because they did not get the 'same' pleasure in the sexual act and 43 per cent because their wives became pregnant. Patel in her Rajasthan study also observed inconvenience and /or embarrassment due to contraceptives which according to her 'is not entirely without justification'.[40] Her respondents reported that 'they (condoms) are menance. It is always difficult to keep them from the reach of children. A condom is like a piece of balloon to them. What an embarrassing sight it is, the condom is blown and people laugh meaningfully'! To others 'disposing it is a problem' and some even reported that 'one can't carry it all the time. What if one needs it in the fields'? On IUD one of her respondent

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[37] J. Mayone Stycos, *Human Fertility in Latin America : Sociological Perspectives* (Ithaca: Cornell University Press, 1968).

[38] Thomas Poffenberger and Shirley B. Poffenberger, "The Social Psychology of Fertility Behaviour in a Village in India," in *Psychological Perspective on Population*, ed. James Fawcett (New York: Basic Books, 1973).

[39] Khan, *Family Planning among Muslims in India.*, pp. 173-174.

[40] Patel, *Fertility Behaviour.*, pp. 187-188, 190.

reported about another woman's agonising experience of IUD- 'ever since the insertion, her menstrual cycle was disrupted. She ultimately has to get it removed, or she would have died leaving behind her children to ruin'. Similarly, about oral pills, one of her respondents reported that 'I would always forget its schedule. For me it never worked'. Interestingly, Patel observed the popular belief among women regarding 'the existence of a contraceptive injection that prevents conception for a period of five years. It is most sought after injection'. It is not clear why Patel noted 'despite popular belief regarding the existence of a contraceptive injection, I was unable to gather more data'[41]? Did she intend to say that contraceptive injection is something that does not exist! Khan rightly concluded that unless the couples are strongly motivated to adopt family planning, slight dissatisfaction, any complication or a single failure is enough for them to stop using the contraceptives.[42] In the sampled population of Jalalpur sub-centre, it may again to be noted that of total temporary adopters, 53 per cent (38) ever temporary contraceptive users are from adopters category while the rest 47 per cent (34) are from non-adopters (table 6.3.1). They together constitute 48 per cent (72) out of the total sample of 150.

Table 6.3.1: Contraceptive history of Adopters and Non Adopters

Sterilisation status	Modern Temporary contraceptives		
	Ever used	Never used	Total
Adopters	38 (53%)	37 (47%)	75 (50%)
Non Adopters	34 (47%)	41 (53%)	75 (50%)
Total	72 (100%)	78 (100%)	150 (100%)

Source: Survey data

[41] Ibid., 190.

[42] Khan, *Family Planning among Muslims in India.*, p. 174.

The table 6.3.2 and 6.3.3 through light on first ever use of specific temporary contraceptive methods by adopters and non-adopters respectively.

Table 6.3.2: Timings of first ever use of Contraceptives by Adopters

Contraceptive Methods	History of contraceptive use			Total
	After marriage to II child birth	III to V child	VI and more	
1. Condoms	3 (19%)	13 (81%)	0 (0%)	16 (100%)
2. Pills	11 (52%)	8 (38%)	2 (10%)	21 (100%)
3. IUD (Cu-T)	0 (0%)	1 (100%)	0 (0%)	1 (100%)
Total	14 (37%)	22 (58%)	2 (5%)	38 (100%)

Source: Survey data

Table 6.3.3: Timings of first ever use of Non Adopters Contraceptives

Contraceptive Methods	History of contraceptive use			Total
	After marriage to II child birth	III to V child	VI and more	
1. Condoms	10 (48%)	10 (48%)	1 (5%)	21 (100%)
2. Pills	2 (18%)	8 (73%)	1 (9%)	11 (100%)
3. IUD (Cu-T)	1 (50%)	1 (50%)	0 (0%)	2 (100%)
Total	13 (38%)	19 (56%)	2 (6%)	34 (100%)

Source: Survey data

As far as use of condom is concerned, the data shows that out of total condom users among adopters, 81 per cent first used it between third to fifth childbirth (against 48 per cent non-adopters during the same period) and the rest 19 per cent first used between after marriage and second childbirth period. The table 6.3.3 also shows that non-adopters have high percentage (48%) of condom users in the period after marriage to second childbirth. Even 5 per cent of condom users among adopters first used it in during sixth childbirth and after. Coming to pills, out of total pills users among adopters, 52 per cent used it during the period between after marriage and second childbirth, followed by 38 per cent and 10 per cent in the period after third child to fifth child; and after six childbirth and more respectively. Unlike condoms, non-adopters lag behind in early use of pills as majority 73 per cent used it in period between third childbirth to fifth childbirth followed by 18 per cent in after marrying to

second childbirth category. There are even 10 per cent among adopters and 9 per cent among non-adopters who first used pills in period six childbirth and more. Only one among adopters used Copper-T (IUD) that also during third to fifth childbirth while among non-adopters out of 2, one use during the same period whereas the other used after marriage and second childbirth period. The tables 6.3.4 and 6.3.5 show the sources from where contraceptives are produced. The table 6.3.4 informs that among adopters, 63 per condom users and 62 per cent pills users purchased these devices from market while the rest availed condoms and pills from government health worker that is ANM.

Table 6.3.4: Adopters Sources from where Contraceptives procured

Contraceptive Methods	Procurement of contraceptives		Total
	Govt. Health worker	Self from Market	
1. Condoms	6 (38%)	10 (63%)	16 (100%)
2. Pills	8 (38%)	13 (62%)	21 (100%)
3. IUD (Cu-T)	1 (100%)	0 (0%)	1 (100%)
Total	15 (39%)	23 (61%)	38 (100%)

Source: Survey data

Similarly, among non-adopters as table 6.3.5 shows 62 per cent condom users purchased it from market while the rest from government health workers. In case pills, non-adopters are much ahead of adopters as 82 per cent pills users among non-adopters (against 62 per cent adopters) purchased pills from market while rest availed from government health worker.

Table 6.3.5: Non Adopters Sources from where Contraceptives procured

Contraceptive Methods	Procurement of contraceptives		Total
	Govt. Health worker	Self from Market	
1. Condoms	8 (38%)	13 (62%)	21 (100%)
2. Pills	2 (18%)	9 (82%)	11 (100%)
3. IUD (Cu-T)	2 (100%)	0 (0%)	2 (100%)
Total	12 (35%)	22 (65%)	34 (100%)

Source: Survey data

It is very pertinent here to note that owing to poor income of both adopters and non-adopters, it is a very significant and encouraging to see that the condom and pill users have high percentage (62-82 per cent) of those purchasing from market. It also points that those who know of devices and used it wants to continue, even if it is to be purchased. It also certifies the encounter we had with community (informal) and with women in FGDs arguing for non-availability of temporary contraceptives at health posts or by government health workers. Our point is not to argue for all time free supply of contraceptives but of the fact that if government or any health worker provides it, then the clients can be properly counselled of the methods usages, initial side effects, if any, and will also have clarifications regarding much prevailed 'myths' about temporary contraceptive usage. The same is quite clear from table 6.3.6 on switch over and FGDs on the same crystallize the bitter experiences of temporary contraceptive users, which can easily be avoided only by a brief clarification.

Table 6.3.6: Adopters and Non Adopters Reason of switch over from one temporary contraceptive method to other

Contraceptive methods	Reasons for switch over		Total
	Usage problem	Side effects	
CC	15 (75%)	5 (25%)	20 (100%)
OCP	7 (39%)	11 (61%)	18 (100%)
IUD	1 (50%)	1 (50%)	2(100%)
Total	23 (58%)	17 (43%)	40 (100%)

Source: Survey data

The above table 6.3.6 shows that out of total 72 temporary contraceptive users in the samples population as much as 40 (56 per cent) have experienced switch over. A many as 20 out of total 37 condom users experienced switch over for reasons like usage problem (75 per cent) and side effects (25 per cent).

Similarly, 18 (56 per cent) out total 32 pill users experience switch over with 61 per cent due to side effects and 39 per cent due to usage problem, more specifically daily schedule of taking pills. Like wise 2 out 3 IUP users left it altogether. One so perturbed of two times IUD insertion that she sought final relief in sterilisation. Savitri (refer **CSN-10**) aged 44 and married at 18 has six children (against 8 pregnancies) she had first IUD insertion at the fifth childbirth but it came out just two hours after the insertion. Thereafter she again went for IUD and it was inserted by the ANM but again it came out just a little later than first experience but in only two days. This however, to any health professionally was expected, because IUD is effective at low parity. At later ages and much childbirths (say after 3-4 children) uterus do not retain it. She than thought of sterilisation but her husband did not agree and result was another childbirth after which she all alone went for sterilisation at the parity of 6 children. This case study of one IUD user (which forthcoming FGD will also support) shows the manner in which temporary contraception is even used by those for whom it will not work. The **FGD-7** illustrates the experiences of ever-temporary contraceptive users. Here temporary contraceptive users are the users of only three methods – condoms (*nirodh*), oral contraceptive pills (pills) and intra-uterine contraceptive device (IUD). This FGD was held with a group of 10 ever-temporary contraceptive users. These ten women were from the sampled population of adopters and non-adopters. They were facilitated to share their experiences of using modern temporary contraceptives. The group first dwelled on procurement of temporary contraceptives and argued that in case of purchasing these (condoms and pills) from market, the husbands do the task. While women normally take these, if available, from government health

workers. In case of condoms, initiatives come from husband's side and women argued that it is their domain. Majority argued that only after their first initiatives, they look for ANM for more supply because husbands sometimes bought it and sometimes not. Group as a whole argued for the casual use of condoms and regularity is only accident. While it may be noted that only one unsafe sexual intercourse may result into pregnancy and that's the reason for their becoming pregnant. The group further shared many hassles in the use of condoms, most important of which was it unrolling and blasting at the critical moments and in many cases couples got so perturbed that they altogether left its usage. Leelawati with 5 children argued there was every risk of pregnancy in condom use while to Suman, 'condoms are most unreliable' as she had two more daughters due to condoms failure and hence both took respite in sterilisation. With regard to pills, the initiatives normally comes from women and taken even secretly. Women also shared it (use of pills) with their mothers-in-law, if it is joint family. Again group showed problems of maintaining schedule in case of pills and the resultant effectiveness. Rajni aged 27 married at 16 having 5 children was very critical of pills as these failed to prevent her pregnancy and birth of a girl child and after which she went for sterilisation. Many non-adopters argued for the unreliability of these condoms and pills and are planning for sterilisation. It may be noted that out of these ten participants in FGD and also ever-users, only 2 clearly know of how to tear up condom from packet, remove air from it and check the proper direction to avoid hassles of unrolling and raptures. Likewise only 4 knew of what to do if they forget a tablet one day, two or more. It is probably these reason that make these methods unreliable and ineffective. Further with regard

to pills group spoke of their hot nature ('*garmī*') and other side effects. Only forty per cent in the group knew of IUD and there were more full of its side effects (rather myths). Some argued that it goes up in abdomen (*pāt mein chād jātī hai*) and other shared the experiences of those in community to whom IUD badly effects.

Thus it is quite clear that the sample population is quite unaware of correct and consistent use of temporary methods and hence their ineffectiveness. There is a need to make them full informed than merely distributing contraceptives to increase contraceptive prevalence rate! A proper counselling to eligible couples about correct and consistent use of contraceptives will be a true step towards Cairo commitment of informed choice of couples and a rationale and viable attempt to curtail fertility than merely increasing CPR.

Traditional Contraceptive methods

Studies have shown that 'a good many people in India practiced fertility control long before they had knowledge of modern contraceptive techniques. They did so for traditional social reasons and by methods traditional in the culture'[43] and that there is 'the need to devote increased research and development resources to promote their use as these methods will be culturally familiar and more acceptable'[44] and also that 'all too often culture is seen as a bulwark of conservatism rather than recognised as a tool for positive

[43] Mandelbaum, *Human Fertility in India; Social Components and Policy Perspectives.*

[44] Chattopadhyay-Dutt, *Loops and Roots : The Conflict between Official and Traditional Family Planning in India.*

change'[45]. A study, known as Baroda Fertility study[46], conducted by the Demographic Research Centre of Baroda University (Gujarat) on a sample of 2520 household shows that 'amongst the females using family planning methods, percentages of those using indigenous methods in both rural and urban areas were about 91 and 77.5 respectively, a large number of housewives appeared to rely on indigenous methods or concoctions prescribed by some local 'wise woman' or by the family matriarch. Some of the indigenous methods including the natural methods reported were- nursing of the baby for a long time, premature withdrawal, douche with oil or some home made herbal solution, rhythm method and abstinence. Patel, very recently and very rightly, noted that these techniques (indigenous techniques of fertility control) are concrete expressions of people's notions of the human body and its physiology. What is significant about these techniques is not their actual efficacy in controlling fertility but the claims associated with them.[47] Patel also dwelled on the typology of indigenous methods and extent of social approval therewith. The indigenous methods observed in practice are abstinence, withdrawal, local medicines and abortions. She noted 'whereas abstinence is institutionalised and culturally upheld, withdrawal is disapproved normatively and practised unobtrusively', and that the local medicines are 'popular exclusively among middle-aged women as they are more desperate than men after acquiring the optimum number of children' while the 'most

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[45] Nat Colletta, *Tradition for Change: Indigenous Socio-Cultural Forms as a Basis for Non-Formal Education* (Berlin: German Foundation for International Development, 1980).

[46] I.V. Bhanot and M.M. Gandotra, "Baroda Fertility Study- a Brief Report," in *Studies in Demography- Essays Presented to Professor S. Chandrasekhar on His Fifty-First Birthday*, ed. Ashish Bose, P.B. Desai, and S.P. Jain (London: George Allen and Unwin, 1970)., p. 481.

[47] Patel, *Fertility Behaviour.*, p. 179.

secretive and least popular of all birth control methods is abortion'.[48] Patel did also explained preparation, composition and timings of administration of local medicines as contraceptives, which deserve attention in any discussion on traditional contraceptive methods as:

> The local medicines are classified into two main categories, depending upon their supposed properties. They are either sticky or cold. A substance is supposed to be sticky in terms of how it gets glued to certain parts of the body. A cold substance is one that is supposed to neutralise body heat. The sticky substances, such as fenugreek, rice and fuller's earth, are usually taken immediately after childbirth. These are supposed to be effective soon after child delivery, when the woman's body is considered tender. These substances are believed to reach the uterus and block entry into the womb before the body regains its original toughness.....Medicines understood to have properties of cooling the body can be taken any time except during the post-partum period (*jāpa*). One of the medicines consists of ground carrot seeds mixed with *hīro* (a sweet prepared with ghee, wheat flour, sugar/jaggery and water). It is taken for a few days on an empty stomach soon after the menstrual cycle is over. As soon as the course is over, it is considered mandatory for a woman to consume *lādu* (a sweet) prepared with five kilograms of ghee. The latter course lasts for about a fortnight. People also believe that if the quantity of ghee is less than the specified amount, the woman is likely to become blind. This makes the medicine so expensive that many mothers-in-law do not allow their daughters-in-law to try it. Certain other cooling medicines are believed to have no adverse effect and can be taken any time other than *jāpa*. These are considered helpful in advancing menopause.

[48] Ibid., pp. 179-180, 182.

> Therefore, they are tried mostly by women in their late thirties or early forties. As these medicines are expensive, they are usually taken under the pretext of body ache and sore eyes (a common ailment in desert conditions). It is difficult for poorer women to take these medicines due to their high cost. Many other women are deterred by severe restrictions associated with the medicines. These include avoiding the sun, smoke, strenuous work and extreme weather.[49]

However, it might have been enlightening if Patel would have thrown more light on 'other cooling medicines' used for contraception.

Thus these studies especially at Gujarat and Rajasthan have highlighted the practice of indigenous fertility control methods. In the study area of Jalalpur sub-centre, the structured interview schedule did not yield much information on traditional methods of contraception. It only reflected that 45 out of total sample of 150 (adopters and non-adopters together) heard of traditional contraceptives, with majority, more than 80 per cent of these, having from peer group (see tables 6.1.1-6.1.4). Only less than a quarter among these very reluctantly specified traditional methods but none spoke and accepted as used, experienced or experimented the same. The methods they specified were withdrawal, excessive breast-feeding (probably they referred to Lactation Amenorrhoea Method, also referred as LAM) and concoctions like *autī* or *kādā* (hot concoctions that are taken orally). Researcher's further prodding at the time of interview did not yielded results beyond this information. The matter was than discussed with key informants who argued for the prevalence

[49] Ibid., pp. 181-182.

of these traditional concoctions in community. ANM particularly explained typology of concoctions. On her suggestion, an informal discussion was held with an octogenarian lady who in past have been a traditional birth attendant (TBA), fortunately she proved to be a very good resource person with knowledge base and understanding of traditional contraceptives. Thereafter, we thought of organizing focus group discussion on the theme of traditional contraception with sampled population. Accordingly a FGD (refer **FGD-8**) was held with a group of women (10 in number) in the latter age group that is 35-45 years, both of adopters and non-adopters. The group was initially asked about traditional methods like withdrawal and LAM. Here ANM played the lead role and group responded with reluctance about the impracticality of withdrawal and argued that many begets children while breast feeding earlier one. It may be noted that their responses were in terms of 'others experiences in the community' and even cited few names or their castes and locations. They finally ended discussion on withdrawal saying that it depends on husbands who rarely practice it (*ye unkāa kām, kucch hi kartē hai aur kar pate hain*). With regard to LAM it may be noted that it is effective only when child is exclusively breast feed with not external supplements. Although in sampled population in particular and rural India in general children are breast feed for very longer durations (even till next child is about to born) but after few months child also starts getting supplement which becomes main nutrient than breast feeding and hence ineffectiveness of LAM. Researchers also raised a related question on mother's first milk to new born and surprisingly all members (in FGD) responded negatively with logic that it is 'impure' and even said that they first gives either butter/honey to child in a cotton piece to

suck it (*pahlā doodh gandā hotā hai, phi yese makkan ya sahad dete hai*). The group was than explained the importance of it and nutrients in it and were given clarifications on the notions of purity and pollution related to childbirth.

With this background the group was facilitated to discuss other traditional contraceptive concoctions (we were earlier told that women do not discussion it openly and kept these as secret treasure of knowledge gained from olds/intimate friends). Initially they showed ignorance and inability to what we were asking and when facilitated by asking about use of *kādā* or *autī* (as mentioned earlier) the ice was broken and each member in group added much information and finally discussed a number of methods as combination of concoctions and how different concoctions are there both for avoiding conception (contraception) and starting menstruation if conception has taken (abortion). They also dwelled over their effectiveness and risky failure cases, which were also, live in their memories. But again in all these discussion notion was 'sharing the experiences of other'. The forthcoming paragraphs summaries the results of FGD in terms of typology, modality, effectiveness and risks of traditional concoctions. It came out that these traditional concoctions could be grouped in two, both in terms of purpose for which it is to be used and the 'intrinsic properties' (*tasheer*) of substance used. It came out that properties of substance/concoctions are of two types – 'cold' and 'hot'. The substance/concoction with cold properties are used to avoid conception while those with hot properties are taken to start menstruation after conception has taken (It also may noted that women, as was apparent from FGDs and field experiences, use menstruation cycle as an yard stick to be sure

of conception (unlike pregnancy detection kit among urban middle classes). In fact, the women who are not in a mood to have another pregnancy, becomes conscious when her periods (cyclic menstruation) did not returns and they wait for it to a maximum of next period time and then their puzzle start to overcome the same and for that they use self prepared traditional concoctions, failing which they either go for 'unsafe abortion' or produced an unwilling child. Patel argued that their unwillingness is even reflected on social ornomastics (that is in the names of children). Thus, hot concoctions in a way are techniques of abortions but owning to stage at which these concoctions are used we safely put them in the category of those 'to restart menstruation' instead along discussions on unsafe abortions (i.e. chapter 3 on Reproductive Trajectory). The concoctions, methods of preparation, effectiveness and risk involve in them are discussed under above two headings i.e. i. 'to avoid conception' and (ii) 'to start menstruation'.

Traditional methods to avoid Conception: As already discussed these methods involve substances which have cold properties. It is believed that high coldness reduces chances of conception. Two substances with high cold properties (*tarī*) are 'banana roots' (*kele ki jad*) and a water born plant ('*pani-bel*'), either can be taken to avoid conception for long time and 'some argued that 'banana roots permanently stop conception'. On usage modality, it came out that these are crushed and their juice is taken two-three days in morning before eating any liquid or solid. These can be taken by both male and female. The group also has the logic with which it works among women. They said '*nashen phūl jāti hain*' which ANM explained that they are referring to

fallopian tubes (*nashen*), which gets swelled due to extreme coldness of these juices and hence conception is avoided. This again reflects their understanding of anatomy and physiology of reproductive system. All were quite confident of their effectiveness for 3-4 years and even it may results in stopping the conception forever and thus these are not for young brides. However, equally they were concerned of side effects and argued that as a result of coldness even body swells and there is severe pain in bones (*gathiā ho jātā hai*).

Traditional methods to start menstruation: A number of methods to start menstruation came up and all are with 'hot' properties. Each method has a specific composition and for women only (needless to add). These are discussed as under –

Carrot seed and Jaggery Mixture: It is group argued, most common method to start menstruation. Basically, carrot seeds and jaggery are boiled at high temperature and then the boiled liquid (*kādā/autī*) is filtered, usually with a cloth, and taken during pregnancy for 3-4 days, 2 times each day. Group argued that it is quite effective as due to 'hot' properties, there is much bleeding and menstruation starts (*māhvāarī chal jatī hai*) which means that there is now no risk of pregnancy. Some also adds crushed *laung* (cloves) in the mixture before boiling and then take the hot liquid for more effectiveness.

Azvāin and Jaggery Mixture: This is again another concoction for abortion or to start menstruation. In practice both *azvāin* (thymol) and Jaggery are mixed boiled, and filtered and product is again taken hot (*kādā/autī*) for 3-4 days or till the period starts.

Tea leaves and Jaggery Mixture: Here again tea leaves are boiled with Jaggery and the boiled liquid is filtered and taken hot for 3-4 days to start the menstruation.

Haldi Fanki – This is non-liquid concoction and taken as powdery materially orally (*fankī*). The group told that *haldī* (turmeric) is roasted and crushed to powder form and then women take at least two *fankī* (two tea spoonful of powdery material) in morning for two-three days. They argued that due to 'hot' effect of *haldī* the period starts. They even argued that it is so 'hot' in nature that one lady died of '*garmī*' (heat) from it. The group told that this method is very effective and risky as well.

Azvāin, Jaggery, Haldī and Andā: This is another concoction in which *haldī* and *azvaīn* are first crushed, than boiled with Jaggery and *andā* (egg). They also added that egg from indigenous hens (*desi andā*) is more effective than those from poultry farms. Again, the boiled filtered liquid is to be taken either once or till period starts. They also argued that sometimes it results in severe pain.

The group as whole argued for the side effects of traditional methods. For example while those with 'cold' properties led to swelling in body and pains in bones, the hot concoctions results in excessive bleeding, fits, digestive disorders and pain in abdomen. They have live stories of many fatal incidents as a result of these traditional methods and also argued that only ladies with many children practice it as they considered it easily accessible and less costly than 'unsafe abortions' and sterilisation. This again reflects the lack of

awareness and effective usage of modern temporary contraceptives and even of access to sterilisation because of which they take recourse to traditional risky concoctions.

Thus, there is a need to counsel effectively against these concoctions as their effectiveness is less and inherent risks are more. One not should be nascent and nostalgic enough to argued for propagation of every indigenous fertility methods. The discussions amply reflected the prevalence of these methods, which needs to counter urgently.

6.4 Undergoing sterilisation- realisation, reactions and repercussions

The Second United Nations Mission noted that 'there is need more carefully to assess the demographic significance of sterilisation. Well designed studies are needed on the characteristics of accepting couples, particularly with respect to recent pregnancy history, parity and age of wife and socio-economic status.'[50] It is noted that 'high parity couples accounted on an average for over 60 per cent of the acceptors of sterilisation in the 1970s and 1980s and over 70 per cent of the acceptors of sterilisation in the 1990s.'[51] Bose made a lengthy remark on efficacy of sterilisation and observed that 'family planning programme centred around sterilisation can only touch the fringe of the problem and cater to the needs of the couples who are about to complete their reproductive life. In any case, there is no basis to think that the recourse to

[50] Nations, "An Evaluation of the Family Planning Programme of the Government of India.", p. 6. Cited in Desai, "The Perspective of India's Population Policy.", p. 423.

[51] Pathak and Singh, "Fertility Transition in India.", p. 178.

sterilisation towards the fag end of reproductive life (though in terms of age this may not be true but what really matters is the number of children born and living and not so much the age of the mother) will bring about the desired impact on the fertility level and ultimately on the birth rate. *The Department of Family Welfare locks the stable after the horse has bolted* [italics mine].'[52] Bose even went to the extent of blaming sterilisation for the utter failure of programme and argued that 'our family planning programme has not succeeded because we have started family planning at the wrong end. Our clients have mostly been women towards the fag end of their reproductive lives. This has happened because we relied heavily on the terminal methods of sterilisation.'[53] However, Pathak and Singh[54] noted that as a matter of fact, due to the use of contraception especially sterilisation, the estimated reproductive life after first birth for India as a whole has decreased from 17.5 years for rural and 14 years for urban in 1972 to 10.7 years for rural and 7.9 years for urban in 1991. In the case of Kerala, however, this was 13.7 for rural and 12.8 for urban in 1972 which came down to 5.6 years in 1991. Even in rural Tamil Nadu, it was just 7.4 years in 1991 as against 17.2 in the case of Uttar Pradesh and 14.5 years in the case of Rajasthan and Madhya Pradesh.

On the perceived complications of tubectomy by female respondents in Khan's study[55] it is observed that a majority of them (43.4 per cent) had no idea about any problem. Of them 18.8 per had not even heard of tubectomy

[52] Bose, *From Population to People.*, pp. 105-106.

[53] Ibid., p. 115.

[54] Pathak and Singh, "Fertility Transition in India.", 184.

[55] Khan, *Family Planning among Muslims in India.*, pp. 136-137.

and only 12 per cent of them saw no problem. Of the females, 7 per cent expressed the fear that tubectomy might cause weakness, fever, illness and that after the operation women would not work hard. Another 9 per cent of the females had a fear of permanent pain in stomach after the tubectomy. Yet another 7 per cent of them mentioned different types of complications associated with the method. Similarly, Caldwell *et. al*[56] and more recently Patel[57] noted the post-operative complications are feared to incapacitate people and bring a couple's sexual life to virtual end. These apprehensions are strengthened by the initial sterilisation experiences of people during the emergency. These experiences are still alive in the collective memory of the people. Patel further observed that 'often the experiences of the sterilized reinforces people's fears and strength their views against it. It becomes a common body of knowledge of people, especially when it results in some complication. *The news spread like wild fire through word of mouth, recurs in gossip, and becomes common knowledge in the village*. These meanings, as part of collective memory, contribute in dissuading other people from accepting it [italics mine].'[58] It is rightly noted that 'the place of sterilisation is important to show the extent of motivation, courage and social approval that the concerned individual has.'[59] It is also noted that 'the survival of a few children, including sons, is a crucial factor behind the decision to sterilize. Each of the sterilised persons on an average have about five surviving

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[56] J.C. Caldwell, P.H. Reddy, and P. Caldwell, "Determinants of Fertiltiy Decline in Rural South India," in *India's Demography*, ed. T. Dyson and N. Crook (New Delhi: South Asian, 1984)., p. 201.

[57] Patel, *Fertility Behaviour*., p. 190.

[58] Ibid., p. 191.

[59] Ibid., p. 194.

children, with nearly three surviving sons, out of six children born to them.'[60] Patel concluded 'our material suggests that the people who adopted sterilisation have in no way digressed from existing norms about the socially optimum family size. The family planning package is accepted only to the extent that it is instrumental in supporting expected fertility behaviour.'[61]

Patel has brilliantly illustrated the dynamics in the process of undergoing sterilisation- 'women consider many factors before they opt for sterilisation. Even if a woman is keen she has to consider the reaction of her husband and other close relatives especially those in the conjugal household. At the same time she has her own fear about surgery and its adverse after-effects, which in popular opinion renders people incapacitated. A person is initially confronted with all popular fears, in the process of deciding to sterilize. During this phase the fears are sorted out individually. Almost all sterilized had shared their fears with close friends and relatives. In such informal discussions, the decision is discussed threadbare with a mixture of humour and seriousness. The pros and cons are weighed. While some fears are dispelled, others are reinforced. The discussion that took place in a circle of close friends, now shift to the spouses. The spouse with higher motivation to get sterilize takes the initiatives. The themes related to sterilisation are repeated. From the pool collective memory the couple recall and discuss other couple's varied experiences. For instance, they recall cases of those who had no post-surgical problem. During such discussions the spouses waver between the two positions: one, favouring and the other against it. It is rare for husband to give

[60] Ibid., p. 195.

[61] Ibid., p. 200.

unqualified permission to their wives for sterilisation especially if they are living in a joint household. In the latter case, parents have greater authority over the couple in such a matter. For a woman the permission of parents-in-law particularly the mother-in-law is crucial if she is residing with them. As a manager of household affair, the mother-in-law's opinion and judgement matters considerably.'[62] However, 'a woman living in a simple household faces an entirely different set of problems compared to one living in jointly with her parents-in-law. The overall responsibility of the household makes her think about all those issues which mother-in-law raises before allowing her daughter-in-law to get sterilize. But once a senior woman decides to get herself sterilized, she somehow manages to seek her husband's support which makes the decision less difficult for her than for a daughter-in-law living jointly in a complex household.'[63] It is also noted that 'the women who acted in open defiance of their husbands' and in laws' wishes were sure of their strength in the household. It is derived partly from a few healthy surviving sons. This provided ample assurance to the mothers that their position in the household could not be easily destabilized.'[64] A more recent study based on a sample size of 300 women distributed across six communities of Chiapas in rural Mexico shows that 'approximately seven out of ten women who had undergone salpingectomies had previously used another contraceptive method. The most prevalent method is surgical sterilisation used by 61.7 per cent of the

[62] Ibid., pp. 202-204. Note: the quote is an aggregate of the selective observation in the noted pages.

[63] Ibid., pp. 206-207.

[64] Ibid., p. 207.

woman, with the being 40.0 to 81.2 across the locations.'[65] Further of the women who have undergone salpingectomy, authors 'found 64.4 per cent participated in the decision. Of these, 41.7 per cent said they had made the decision jointly with their husbands and 22.7 per cent said they have made it on their own; 35.6 per cent had no say in the decision'[66] and 'the largest percentage of contraception decision made by other people occurred among women in the willingly home based category, namely women who accept and perform traditional gender roles'[67]. With regard to reasons women also said 'they had undergone a salpingectomy for either economic reasons (70.2 per cent) or health related reasons (29.8 per cent).'[68] In a nationwide study, Jaun Guillermo Figueroa (1989) 'found that 26 per cent of the women who had been sterilized did not have any prior information about the contraceptive method and irrevocable aspect of the surgery. Forty per cent of the women were never asked to sign a consent form permitting the procedure and those who have asked did not read it. Most of the women of the rural Chiapas whom we studied were similarly unaware of the exact nature of the procedure.'[69] On the benefits of sterilisation, authors noted that 'personal well being varied greatly between women of different socio-economic backgrounds. While for some the operation led to a reduction of domestic chores, satisfactory paid work, and greater sexual enjoyment, for others it was a survival strategy to

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[65] Beutelspacher, Martela, and Garcia, "Does Contraception Benefit Women? Structure, Agency and Well Being in Rural Mexico.", p. 275.

[66] Ibid., p. 277.

[67] Ibid., p. 281.

[68] Ibid., pp. 277-278.

[69] Ibid., p. 278.

prevent a further deterioration in their quality of life.'[70] In regard to post-operation perceptions, authors observed that 'of 47 per cent women who did not participated in the contraceptive decision, 68.1 per cent felt frustrated because they could not fulfil their desire to have more children. This was in contrast to 35.3 per cent of the women who did participate in the decision. In fact 80.6 per cent of all women who expressed their desire to have more children after the operation saw children as an important source of affection.'[71]

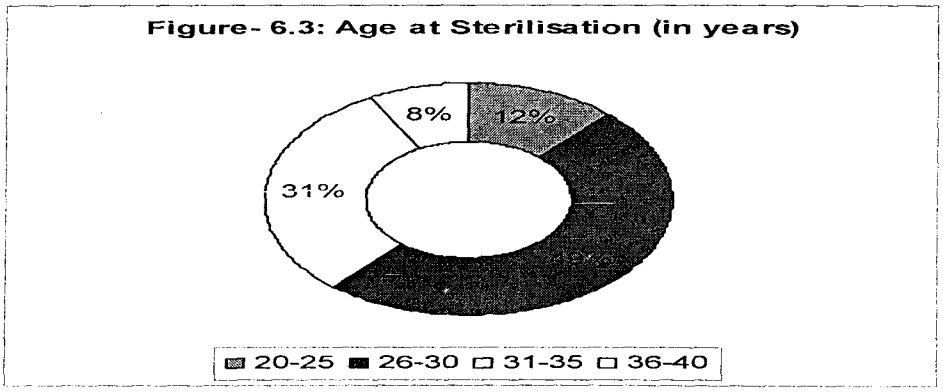
With this brief stretch the discussion here reflects the experiences and profile of 75 sterilisation adopters from Jalalpur sub-centre of Lodha Block, Aligarh. The table 6.4.1 and **figure 6.3** reflect the age of adopters at the time of sterilisation.

Table 6.4.1: Age at Sterilisation

Age (years)	Sterilisation Adopters (No. and Per centages)
1. 20-25	9 (12%)
2. 26-30	37 (49%)
3. 31-35	23 (31%)
4. 36-40	6 (8%)
Total	75 (100%)
Mean Age	29.2

Source: Survey data

Figure 6.3: Age at sterilisation (in years)

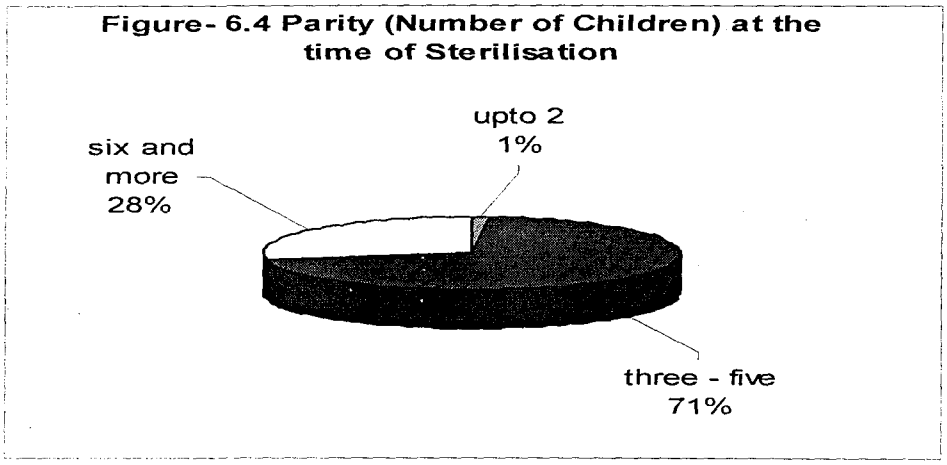


[70] Ibid., p. 281.

The data show only 12 per cent undergone sterilisation in 20-25 years age group while in next age group 26-30 years, there are 49 per cent. While 31 per cent undergone sterilisation while in 31-35 years age group followed by even 8 per cent who have undergone sterilisation while in 36-40 years age group. The mean age at sterilisation comes to 29.2 years. After the age at sterilisation, another very important parameter to understand the importance and effectiveness of sterilisation on total fertility rate (TFR) is the total parity (number of children at sterilisation).

The **figure 6.4** shows that 71 per cent of sterilisation adopters in the study went for sterilisation at the parity between 3-5 children while 28 per cent even went for it at six and more parity. Only one per cent (1 out 75) has undergone sterilisation at the parity 0-2 children.

Figure 6.4: Parity (number of children) at the time of sterilisation



To fully understand the dynamics of sterilisation adoption and parity matrix let's discuss two case studies. One case study is that of an adopter who has

[71] Ibid., pp. 278-79.

undergone sterilisation at only 2 children (refer to **CSN-11**) and while second is that of a lady who has adopted sterilisation after 8 children (refer **CSN-12**). CSN-11 is that of Anita aged 27 (married at 20 years) and has undergone sterilisation at age of 23 years with two children. Anita lives in joint family and her husband is the main bread earning. The family consists of couple, their children and father-in-law, a total of 5 members. Anita is educated up to primary level and is a housewife. Her father-in-law is also educated up to senior secondary (IX-X) level and is old enough to work any more. Her husband also has education up to primary level and works as a skilled worker in lock factory at Aligarh city and earns Rs. 1500 per month. The family is a high caste Hindu family with no land, no political background. On being asked why she adopted sterilisation, she argued that owning to family income and concern to give better bringing to children we thought very early to have less children. After first childbirth (a male) she started pills to space the children but she finally ended up with another children, a male. She said with grace of God both child were male (*bhagwān ki kripāa se dono ladkēe thē*) she thought to limit family and discussed it with her husband, who on use of pills gave simple consent but this time his response was that of rejection. He cited the 'early age of Anita, her health and small children, as reasons for not adopting sterilisation now' told Anita. However, she got indirect consent from her father-in-law. Anita argued that she was certain that in soon she would have more children. She was determined to adopt sterilisation as only reliable method to be sure of no pregnancy. Finally, she took her outright decision in the 'name of God' (Anita told) and went for sterilisation. She is also very satisfied with sterilisation even after 4 years of operation and told us that she

has motivated many women about sterilisation and the virtues small size family. What was apparent in her case was her positive outlook, and very clear understanding that 'large numbers of children are unaffordable'. Another point that should be kept in mind is that Anita has her first two children both males and probably this was a very strong supporting point for her. From her talks, irrespective of other attributes, it was clear that had she not gave birth to two male children; it was very difficult for her to adopt sterilisation. In that condition she might not have went against her family even if she had a thought. However, Anita works as model for others and ANM confirms the same. CSN-12 is that of Aara who had undergone sterilisation at a parity of 8 children (against 11 pregnancies). Aara at present is 35 years old and got herself sterilised at the age of 33 years. Aara is a Muslim and belongs to OBC category and lives in nuclear family. She is illiterate and housewife while her husband is educated up to primary level and works as an unskilled worker and earns Rs. 2000 per month. Both were married at a time when Aara was 18 years and her husband Noor Islam was 24 years old. Looking over reproductive trajectory Aara has given birth to 8 children and has experienced one natural abortion and 2 induced abortion, which were unsafe and one unsafe abortion led her to life threatening stage and finally she reached district hospital, where according to her at a huge investment of Rs. 5000, she was saved and in process sterilised as well. However, to understand her better, let's look over her contraceptive history. Aara first experienced use of condom after fourth child \birth but argued that 'it was very difficult to use condoms' and she gave birth to two more children. After sixth childbirth she used pills purchased from market but she argued these led to '*garmī*' (heat in body), this

is commonly cited side effect of pills. Aara lamented on the non-availability of health services, health personnel and free contraceptives. She argued that she has 'invested much money on purchase of condoms and pills' which her husband brought from market. She also told that 'both of them were planning for sterilisation but due to fear of operation and proper support and classification' she delayed. She laments on abortion and even argued that this is risky and unreligious (*khataknāk hai, manā bhī hai*) but on other hand continued to add, it was a compulsion, how to feed so many children. This case study again shows the unreliability of temporary methods owing to lack of information on correct and consistent use of temporary contraceptives, which is a must for effectiveness. It shows and certifies high unmet need for contraception, poor availability of health and family planning services, irrespective of huge investment on free supply of contraceptives. More interestingly in UP also there is high CPR (contraceptive prevalence rate) in contradiction to TFR (Total Fertility Rate). Probably, the data collected, previous FGDs and case studies only reflects concoctions in CPR compilation.

The table 6.4.2 and figure 6.5 show the most important reasons for undergoing sterilisation. On the question regarding one most important reason for sterilisation 43 per cent responded that they don't want any more child, followed by 36 per cent who have undergone sterilisation due to economic compulsions. Another 8 per cent argued for quality upbringing of children, 7 per cent cited their health concern while 5 per cent said that their children are going to marry/married and in only one case husband pursued for sterilisation.

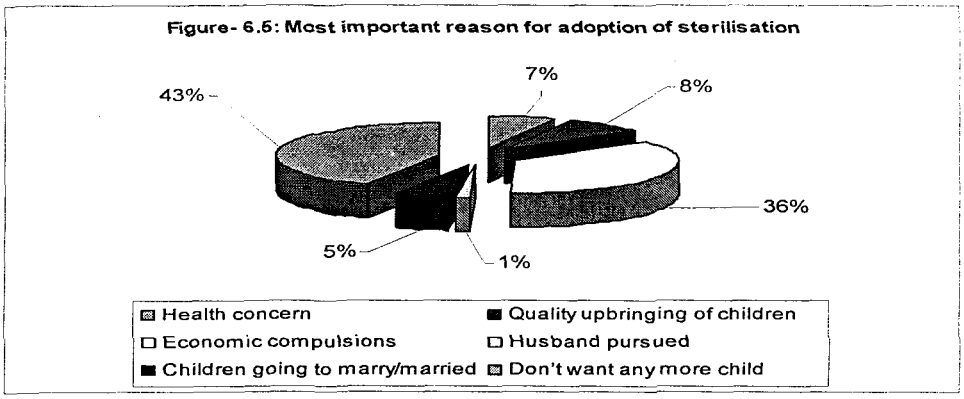
It may be noted that reason like motivation by health worker did not figure in the total sample and get zero value, this again reflects poor approach and inability of health workers in motivating the people for family planning.

Table 6.4.2: Most important reason for the adoption of Sterilisation

Reason	No (%)
Health concern	5 (7%)
Quality upbringing of children	6 (8%)
Economic compulsions	27 (36%)
Husband pursued	1 (1%)
Children going to marry/married	4 (5%)
Don't want any more child	32 (43%)
Total	75 (100%)

Source: Survey data

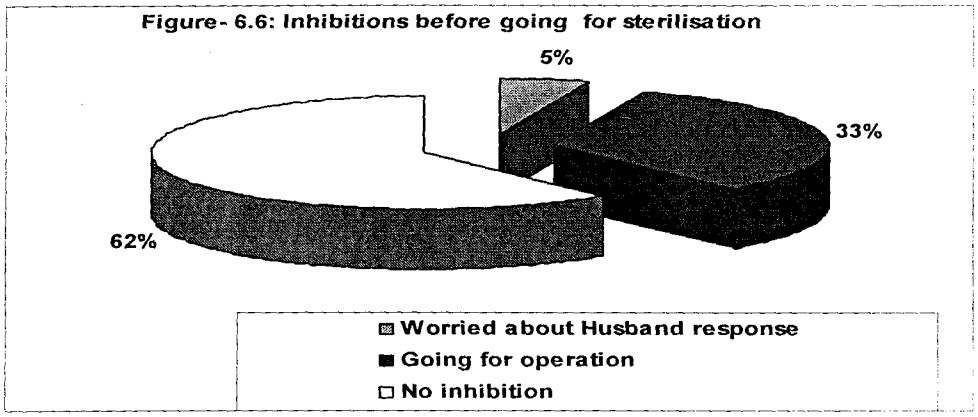
Figure 6.5: Most important reason for adoption of sterilisation



The figure 6.6 shows that a good majority 62 per cent did not have any inhibitions while 33 per cent were fearful of undergoing operation ('in rural matrix term operation is phobic in nature, whether minor or major) followed by 5 per cent who worried about husband response as they have gone against the spouse wishes or reluctance. It may be noted that questions like inhibitions related to community pressure and religious notions did not surfaced as impediments while finally deciding to go for sterilisation. It may however be read with condition that due to heavy load of pregnancies and unaffordable

children and hence don't want any more children (43%) or due to economic compulsions (36%) and both of these are related and reflects the economic constraints and inabilities of family to afford any more children. The data also informs that out of these, 29 (38 per cent) who have inhibition, 8 sought classification from peers, 7 each from government health worker and husband, 4 from significant others and rest from voluntary health workers in community and other sources.

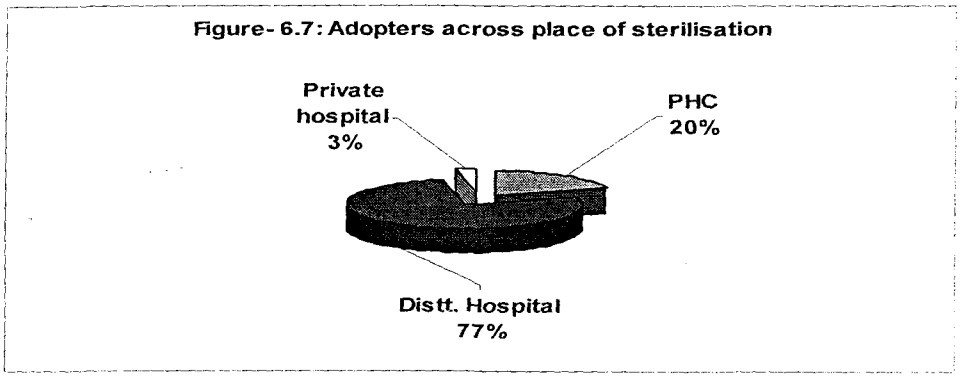
Figure 6.6: Inhibitions before going for sterilisation



After inhibitions before sterilisation comes the knowledge of irreversible nature of sterilisation. Interestingly in present research only 69 out of 75 adopters that is 92 per cent knew that sterilisation is irreversible while 8 per cent did not know that sterilisation is irreversible. On further probing it comes that this especially happens when clients reached the district hospital or private clinic as result of co placations due to unsafe abortions or they go for abortion owing their health, which is too poor too, afford anymore child and in that case husband in consultation with doctors agree for sterilisation. Few have became confused owning to tubectomy failure cases in the locality. In regard to signing of consent form, data show that 93 per cent (70 out 75) adopters

told to have signed the consent form before undergoing sterilisation, of the remaining 7 per cent (5 adopter), one know that she has not signed, two said their husbands have signed while another two don't know about consent form nor did they recall of any such thing at the time of operation. In regard to reading or hearing the content of consent form, 57 out of 75 (76 per cent) neither heard the content nor did they read it (which majority can't do owning to illiterate 73% refer to table 3.2.1). Only 17 (22%) read it while signing and one told that her husband signed the form. The figure 6.7 shows the adopters across place of sterilisation. Out of the total adopters in the sample 77 per cent undergone sterilisation at district hospital, 20 per cent at PHC (Primary Health Centre) at the Block and rest 3 per cent had it at private hospital.

Figure 6.7: Adopters across place of sterilisation



In terms of pre and post sterilisation services, the data in table 6.4.5 show that in case of pre-adoption counselling only 55 out of 75 (73 per cent) received the counselling. The table 6.4.5 also shows that only 69 per cent at district hospital (i.e. 40 out of 58 sterilised cases) received pre-adoption counselling, followed by 13 out 15 (86 per cent) at PHC while all those (2 out 2) who have undergone sterilisation at private hospitals received pre-adoption counselling.

In terms of follow up services, 80 per cent received the same. All at private hospitals received the same; while 12 out 15 (80 per cent) in case of PHC and 46 out of 58 (79 per cent) at District hospital received follow up service. However, it should be cent per cent at least the first and second follow-ups are must and necessary to repose and sustain faith of clients, apart from proving needed services and most importantly clarification to client and to her family members.

Further, the table 6.4.3 also shows that in case of their satisfaction with sterilisation and services, adopters are kind enough in responses, as 13 out 15 at PHC, 54 out of 58 (93 per cent) and all at private hospital as place of sterilisation showed their satisfaction. However, this may also be noted with a pinch of salt. For example only 53 out of 58 sterilisation cases at district hospital were successful while those who are satisfied with sterilisation and services are 54 (one more) in number.

Table 6.4.3: Distribution of services on Sterilisation across place of Sterilisation

Services	Number of Adopters			Total
	PHC	Distt. Hospital	Private hospital	
Pre- Adoption counselling	13	40	02	55
Follow up services	12	46	02	60
Success	14	53	02	69
Satisfaction	13	54	02	69

Source: Survey data

One being asked from a adopter whose sterilisation resulted in failure, for giving response of satisfaction, she replied what more to say? (*kahne ko kyã hai*). In fact she has suffered series of ordeals after her sterilisation failure, which are discussed in **CSN-13**. In regard to general complications as table

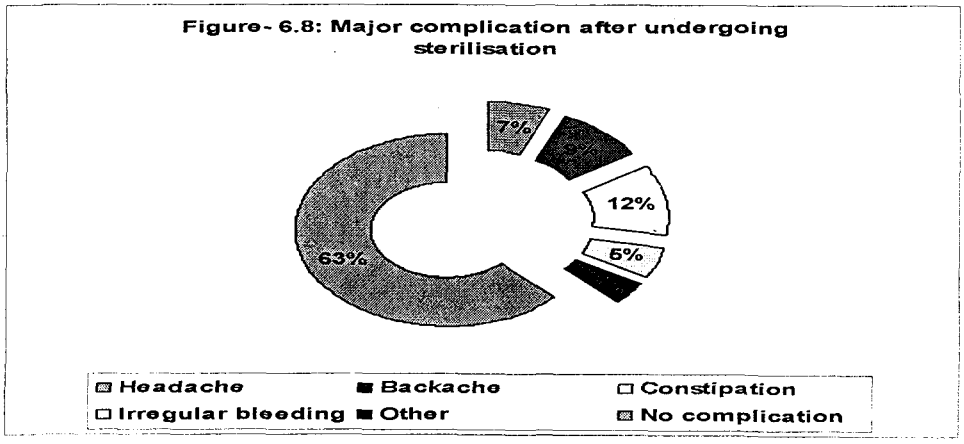
6.4.4 and figure 6.8 together show that 63 per cent of adopters did not experience any post-sterilisation complication while 12 per cent experience constipation followed by 9 per cent with backache problem, 7 per cent with headache, 5 per cent with menstrual disturbance (irregular bleeding) and rest four per cent cited other reasons. It may here again be noted that although the percentage of those with complications is less, the same may declines if counselling would be provided. For example at later stages 30-35 plus menstrual disturbances are normal and they may have been counselled for the same.

Table 6.4.4: Major complication experienced by the adoption of Sterilisation

Complications	No (%)
Headache	5 (7%)
Backache	7 (9%)
Constipation	9 (12%)
Irregular bleeding	4 (5%)
Other	3 (4%)
No complication	47 (63%)
Total	75 (100%)

Source: Survey data

Figure 6.8: Major complications after undergoing sterilisation



Before moving to other positive and negative consequence of sterilisation, lets first have a look over the plight of those with failure of sterilisation. CSN-13

refers to Gayatri who had undergone sterilisation four years earlier at the age of 32 years with 5 children (4 sons and 1 daughter). But very next year she conceived and gave birth to a child (female). With this failure of sterilisation Gayatri literally passed through a series of ordeals. Her husband, (both live in nuclear family) a temporary Home Guard, harassed and beaten her severely. Thereafter, she tried condoms and pills but ended up with two or more unsafe abortions and now, when we interacted with her, she was in a very poor physical and psychological condition. Just few days before, we interacted, she has undergone sterilisation and condition was very aphetic and she was much fearful of further ordeals of abuse, pregnancies and abortions. She is willing again to go for sterilisation as according to her condoms and pills do not work but her husband is much against re-sterilisation and even abuses those who talked to him on this matter. This shows a plight of sterilisation failure on one hand and heavy pregnancy load on mothers on other.

So for as general benefits of sterilisation to adopters are concerned, the table 6.4.5 shows that 87 per cent opined that it reduced the risk and concern about unwanted pregnancies and enhanced sex life, rest argued for reduced domestic work (4%), status upgradation in family (4%), husband satisfaction (3%) and similarly equal 3 per cent told about more freedom to carry out activities.

Table 6.4.5: Personal Benefits of Sterilisation Adoption

Benefits	No (%)
Reduced risk and concern about unwanted pregnancies/ enhanced sex life	65 (87%)
More freedom to carry out activities	2 (3%)
Reduced domestic work	3 (4%)
Status upgradation in family	3 (4%)
Husband satisfaction	2 (3%)
Total	75 (100%)

Source: Survey data

In terms of social consequences after sterilisation, the table 6.4.6 shows that a large majority of 84 per cent across caste, and religion argued to experience initial community sanctions which range from gestures to comments, as still people (elders) in community do not consider it good to go against nature. Another, 9 per cent told of rift in family as a consequence while only one respondent experienced sanctions on the observance of religious rituals. However, all respondents (**FGD-9** will crystallize later on) were quick to add that in little course of time, everything become normal (*sab thīk ho jātā hai*).

Table 6.4.6: Social Consequences of Sterilisation Adoption

Social consequences	No (%)
Rift in family	7 (9%)
Community sanctions	63 (84%)
Sanctions on observance of religious rituals	1 (1%)
Other	04 (5%)
Total	75 (100%)

Source: Survey data

In terms of the advocacy by the sterilisation adopters the table 6.4.7 shows that with 77 per cent adopters other women came to seek their advice while 72 per adopters themselves motivated other women for sterilisation and gave clarification to those in confusing stage, while another 47 per cent were used by health worker as a model to motivate others.

Table 6.4.7: Advocacy by Sterilisation adopters

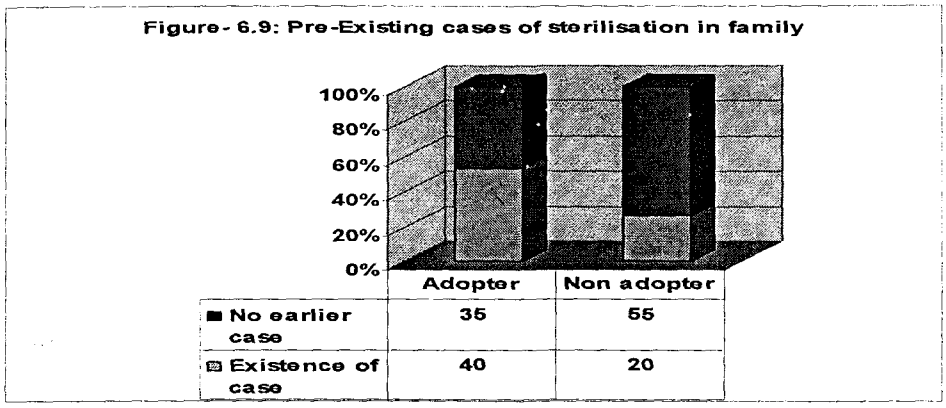
Modelling Sterilisation adaptors	No out of total 75
Other women approached to seek advice	58 (77%)
Herself motivated others	54 (72%)
Health worker used as model	35 (47%)
Other in family imitated	21 (28%)

Source: Survey data

Within the family, in 28 per cent cases, other family members get motivated by sterilisation adopters and imitated them. It may also be noted that more

than 53 per cent of sterilisation adopters had a pre-existing case in their family unlike 27 per cent in case of non-adopters (**figure 6.9**).

Figure 6.9: Pre-existing cases of sterilisation in the family



The following FGD (**FGD-9**) will through light on more subtle and qualitative dimensions related to those who have undergone sterilisation. The FGD-9 was organised with a group consisting of 10 women with sterilisation; all belong to SC and majority worked in nearby lock manufacturing units. They are mainly engaged in cutting processes, which fetched them each Rs 400-500 per month. They have gone for sterilisation after having average 4.7 children (2.9 males and 1.8 females) against average 6.4 pregnancies. The age of sterilisation of the group was 29.3 years. The discussion centred on the process of sterilisation adoption: reasons, initiatives, responses of family members, parity at sterilisation and also common post-operation consequences. The group argued that most important reason is the number of children who becomes unaffordable in view of limited income of both husband and wife (average Rs 1700 per month). Further, they showed their concern for the education of their children. They were highly under the influence of demonstration effect and lamented for their inability to send all their children to schools. Further

women were highly concerned about their sharply deteriorating health in wake of number of pregnancies and childbirths and when this becomes beyond limits the sterilisation is the recourse. On the issue of initiatives and discussions with family members, all said initially they discussed their idea of undergoing sterilisation with spouse but they prolonged matter citing complications, weakness and poor health of their wives. In process they got one-two more children along with half hearted unsafe abortion attempts. Mother in-laws (in case of joint family) also show reluctance. Thus under the prevailing situations and to avoid risk of any more pregnancy, they themselves have gone for sterilisation with the help of ANM and other co-workers (who had sterilisation) but without informing their husbands and in-laws. Their apparent 'self decision' is result of failed mobilisation of their husbands and resulting pregnancies compelling them to take unilateral decision. The group was also facilitated to dwell on fear of sterilisation. One lady boldly argued and was supported and acknowledged by others that we are left with only choice, either die by living with hunger or die of complications but if saved you have respite from more pregnancies and children and one can then work to feed and nurture the children who are already more than what is affordable. On the question of number of children after which to go for sterilisation the group argued that initially the approach at young ages is to have more and more children (maximum) but once number of children becomes burden and difficulty to feed, one think of having and less (*jab chānd par padti hai to samajha āta hai*). This statement clearly shows the gap between desired and actual family size. Interestingly, when asked for ideal family size they said for 2 or 3 only while at the same time having 5-6 children. On the issue of post

sterilisation complications the majority did complaint of weakness, gastric problems, stomachache and backache even after 1-2 years of operation. But to some, these complications are nothing in comparison to burden of any more child birth and consequent hunger plight. Some old ladies, though not part of FGD, sitting along side boast of type of sterilisation they had undergone. They talked of '*teen tanka nasbandi*' that is tubectomy benefits and less complications in comparison of '*durbeen nasbandi*' that is laparoscopic sterilisation. This may also be due to fact that in year 2005-2006 the same village has witnessed five-cases of sterilisation (laparoscopic) failure which is in memories of all. According to ANM these failures have distorted her well-developed field. About modern temporary contraceptives the group was knew of condoms and pills. However the use of temporary method was limited, few used 'pill' that also during last pregnancy but they hasten to add that 'schedule was not maintained and result was unwanted pregnancies'. Few talked of aborting the unwanted pregnancies by taking local medication like tablets capsules but failed. Thus to them sterilisation seemed to be only remedy. The discussion was much open, smooth and also exhaustive. ANM performed the role of icebreaker and let the ball rolling; the discussion was streamlined and concretised by researcher, who facilitated the group with issues to be discussed.

6.5 *Contraceptive Non-adopters*

Marshall[72] noted that the family planning programme is source of new cognitive input into a pre-existing cognitive structure. It attempts to change individuals' perception regarding family planning by propagating the positive consequences of birth control. On this Khan[73] observed that it is possible that the perceived good consequences of adopting family planning were outnumbered by the constraints against it. He quotes a number of studies[74] which have observed that the factors like religious values, fear of complication and opinion of significant others may work as constraints against family planning. Very recently, K.P. Neeraja[75] study of 800 fecund women in Andhra Pradesh shows that major reason for non adoption by respondents were- the fear of side effects (23 per cent), need of more children (20 per cent) and unwillingness of husband (20 per cent).

Never Contraceptive Users- typology of reasons

The table 6.5.1 shows the major reasons for non-adoption of any contraceptives temporary or permanent. It shows that out of total 75 non-adopters, 41 were never contraceptive users. Among these 41, 44 per cent argued that they do not need contraceptives (*zarūrat nahin*), 22 per cent do not

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[72] Marshall, "A Conceptual Framework for Viewing Responses to Family Planning Programs."

[73] Khan, *Family Planning among Muslims in India.*, p. 10.

[74] Driver, *Differential Fertility in India.*, Poffenberger and Poffenberger, "The Social Psychology of Fertility Behaviour in a Village in India.", M.E. Khan, "Reasons for Preference or Rejection of Family Planning Methods," *The Journal of Family Welfare* XXXIV, no. 1 (1977)., M.E. Khan and C.V.S. Prasad, *Family Planning in Indian Industries- a Study of the Role on Incentives in Promoting Sterilization among Worker's* (New Delhi: Manohar, 1977). See Khan, *Family Planning among Muslims in India.*, pp. 10-11.

[75] Neeraja, *Rural Women- Maternal, Child Health and Family Planning Services.*, p. 240.

know about family planning devices, to 5 per cent contraceptives are not easily available, 7 per cent said their husbands disfavour it and rest 17 per cent are afraid of side effects.

Table 6.5.1: Distribution of contraceptive Never Users across main reasons

Reason	No (%)
Don't know about FPDs	9 (22%)
Not easily available	2 (5%)
No need	18 (44%)
Husband disfavor	3 (7%)
Significant Others against	1 (2%)
Side effects	8 (20%)
Total	41 (100%)

Source: Survey data

It may also noted that reasons like 'against religion' and 'experience' did not figure here and dropped in final tabulation. This again shows that to never adopters, religion or caste is not the main reason for not using any contraceptive device.

Non Sterilisation Adopters- understanding concerns and constraints

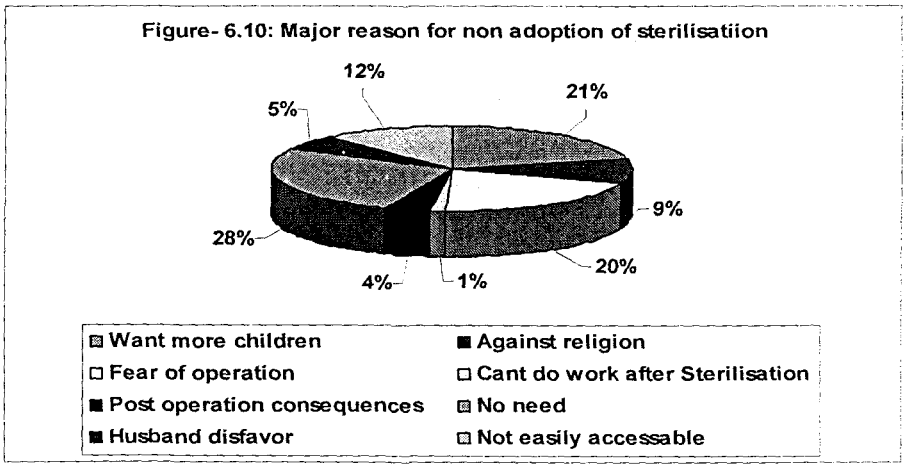
Coming to reasons for non-adoption of sterilisation, the table 6.5.2 and figure 6.10 show that to 27 per cent there is no need of sterilisation, while 21 per cent want more children, while 20 per cent have fear of operation, to another 12 per cent it is not easily accessible, 4 per cent fear of post-operation consequences while 5 per argued that husband disfavour. Here in case of sterilisation, 9 per cent argued that sterilisation is against religion. It may again be noted that many women both Hindu and Muslim argued that sterilisation is against nature and they avoid it until compelled by pregnancy loads, and economic constraints.

Table 6.5.2: Most important reason for non adoption of Sterilisation

Reason	No (%)
Want more children	16 (21%)
Against religion	7 (9%)
Fear of operation	15 (20%)
Cant do work after Sterilisation	1 (1%)
Post operation consequences	3 (4%)
No need	20 (27%)
Husband disfavour	4 (5%)
Not easily accessible	9 (12%)
Total	75 (100%)

Source: Survey data

Figure 6.10: Major reasons for non-adoption of sterilisation



Further those who want more children are just 16 in number and out of these as table 6.5.3 and figure 6.11 show that 13 out of 16 (81 per cent) want at least 1-2 more children while rest want 3-4 more children. This may be read with fact that among non-adopters 3 respondents did not have any child (table 4.5.1) at the time of survey.

Table 6.5.3: Expected number of more children after which to go for Sterilisation

No of children	No (%)
1-2	13 (81%)
3-4	3 (19%)
Total	16 (100%)

Source: Survey data

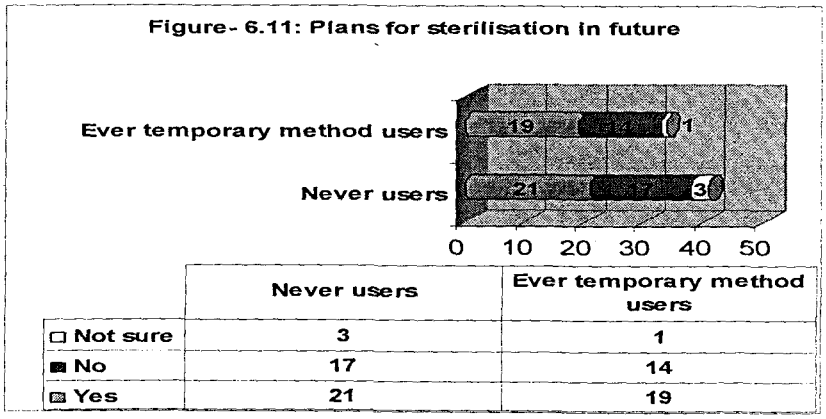
The non-adopters were also asked of their future plans for adoption of sterilisation. The table 6.5.4 and figure 6.11 show the future plans for sterilisation across two categories of non-adopters i.e. ever temporary users and never contraceptive users. As much as 51 per cent never contraceptive users plan sterilisation in future (against 56 per cent ever users), while 41 per cent among never users (against equal ever users) said they answered negatively. Rest 7 per cent among never users, 3 per cent among ever-temporary uses and 5 per cent of total non-adopters argued that they are not sure of sterilisation in future.

Table 6.5.4: Future Plans for adoption of Sterilisation

Contraceptive history	Tubectomy planning in future			Total
	Yes	No	Not sure	
Never users	21 (51%)	17 (41%)	3 (7%)	41 (100%)
Ever temporary method users	19 (56%)	14 (41%)	1 (3%)	34 (100%)
Total	40 (53%)	31 (41%)	4 (5%)	75 (100%)

Source: Survey data

Figure 6.11: Future plan for sterilisation



To further understand the rationale of never contraceptive adopters and non-sterilisation adopters, the FGD is conducted and summary of the same is presented here. **FGD-10** was conducted with a group of 15 women in the age

group 20-30 years, all married with married life of more than 4 years. The group represents both ever-temporary contraceptive users as well as never users but all belong to non-sterilisation adopters category. All the participants were housewives and illiterates minus four who studied up to primary level. Further among these 6 have ever used temporary contraceptive methods. The group was not much awareness about temporary contraceptive devices. They have only heard of condoms, pills and sterilisation. All knew of sterilisation but only 11 heard of condoms and pills and out of those, 2 were condoms users and 4 were pills users. Rest 5 who heard of condoms did not know the right use of condoms and schedule to be adhered with pills, what if they forget to take pill on one day, from which day of menstrual cycle they should start taking pills etc. They did lament for non available of correct information. However, the two condom users were satisfied and gave credit to their husbands who brought it and know how to use and even argued 'they' (husband) are to understand it as they are to use it (*unhen karnā hai, hamēen kyā*). Among the pills users, all have used it in past and are not using these, two have breast feeding children and two just left these. They also argued for the effectiveness. Thereafter, we explained them the correct use of condoms and pills, initial precautions to be taken to overcome the hassles in condom use- most common is the unrolling of condom and it blasting which creates fuss at critical moments. The group was also given information and clarification on how the timings of taking pills are important and how they should follow their menstrual cycle (*māhvāri*) and what to do if they forget taking pills for one day or two days and also what to do if forgets for more than 2 days. The group was very receptive in seeking the information and

facilitation by ANM and ASHAs was very significant in the process. The group showed much concern for temporary contraceptives as all of the group members were with two and more children. The high parity (3 plus) women asked more on sterilisation while younger group argued against it. These women with three and more children told that many times they thought of sterilisation but are afraid of operation (*aprēsan*), they were given clarification on the same. One lady also asked about incentives and continued to add that earlier 'women did get land for undergoing sterilisation'. The group as whole was clarified that no such scheme exists any more and moreover it is in their interest to restrict family size so that they themselves have better living and provide quality upbringing to their children. They were also classified that we are not there to take 'case' (woman to fulfil sterilisation targets) and they themselves have to decide how best to restrict family size by the use of temporary contraceptives or by undergoing sterilisation. The clarification on our part became important as one of the spouse whisper to his wife who was coming to participate in discussion that they are here to find sterilisation cases (*wo nasbandi ke liye aye hain*). However, the point is important as it is only towards the closing months (Jan-March) of annual year that health personnel's and even grass-root level workers of allied departments energized to find 'cases' to complete the prescribed 'target'. Still they are to go for 'targets', which becomes more cumbersome when any collector (District Magistrate) gives more focus on this.

What was more important to see in these discussions was the confusing and pendulating response on contraceptive (temporary or permanent) adoption. At

one moment they showed much concern and on other also added that there is 'no need, all will be correct' (*zarurat nahin sab theek ho jayeka*). However, it did come out from discussions and experience sharing with them that the answers like 'no need' are nothing but 'escapist answers' to satisfied themselves. It is also equally important to see that on temporary contraceptives there were no inhibitions/concern relating to religion or even cost.

Thus on the basis of insight developed from quantitative data in tables 6.1.1-6.5.4 supplemented by focus groups discussions (FGD 5-10) and case studies (CSN 9-12) it may not be exaggeration to argued that the sampled women only needs 'threshold energy' to become active. In order to promote family planning, this role of a catalyst has to be played by ANM, AHSA and a mechanism needs to be created in the community itself for the same. Only in regard to sterilisation they were reluctant, and argued that it is against nature and God will punish but those with three-four children were conscious of their conditions which are to be further deteriorated with more children, showed much concern (though confusions) for sterilisation. Meaningby, in case of sterilisation too, a little more impetus is needed to enable and facilitate these women to have sterilisation, which they finally go by themselves but after one-two unintended and unwilling children, with one –two induced abortions and then run away (literally) to have sterilisation. It may be noted that in many FGDs, such instances of desire to undergo sterilisation came up (across caste, religion, family type) where women agreed for sterilisation and asked for help from us, some for talking to their husbands, in laws, some to ensure support from ANM which we gladly and successful did in majority of cases.

CHAPTER-7

CONCLUSION AND WAYS FORWARD

CHAPTER-7

Conclusion and Ways Forward

The population growth in India is a global issue. The growth of population in India is an important determinant of the growth of the world population.[1] The largest countries (China and India) constitute about 38 per cent of the world population; they mainly determine the size of the world population. India has relatively large growth rate. The rate of population growth in 1992 in China and India was 1.5 and 2.0 per cents respectively, and, therefore, though India's current population size is less than that of China, yet it will add larger numbers to the size of the world population.[2] In a country of India's massive population size and incredible diversity, all generalisations, theories and models are hazardous.[3] However, in the present research an attempt is made to understand the dynamics of personal and familial characteristics in the adoption of family welfare programmes based on a sample of 75 sterilisation adopters and equal (75) non-sterilisation adopters. The study is undertaken in the light of well-defined objectives and hypotheses and the data thus collected are analysed in specific chapters. This chapter presents the results of study in a more cogent way and in the light of the results ways forward are proposed.

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[1] Talwar, "Determinants and Consequences of Rapid Population Growth.", p. 34.

[2] Ibid., p. 34.

[3] Bose, *Beyond Demography- Dialogue with People.*, Preface, pp. x-xi.

7.1 Results

The results of the present study are summarised here with reference to major objectives of the study and the hypotheses set forth for testing. This sub chapter is divided into four major headings which represents for major objectives of the study and thus in the coming paragraphs under each heading one major objective and related hypothesis have been discussed.

Personal and familial characteristics

The present research began with an analysis of data on major and much acknowledged and commented upon socio-economic variables determining fertility and family planning adoption. The socio-economic variables taken for data analysis are religion, caste, family type, land holdings and political participation. In terms of religion there are two major categories that is Hindus and Muslims. It came out that among the total Hindus in the sample 48 per cent are sterilisation adopters and 43 percent are ever-temporary contraceptive users. Among the Muslims, 54 per cent are sterilisation adopters and in terms of ever-temporary contraceptive usage their percentage is 59. The focus group discussions (FGD-1 and FGD-2) amply crystallises the religious worldview of sampled population vis-à-vis contraception. In the sampled population both Hindus and Muslims do not have religious inhibitions/constraints for temporary contraceptives, rather there seems to be a high unmet need for temporary contraceptives and it was quite apparent in their arguments on non-availability of free contraceptive supply. Both groups considered sterilisation

as against nature and a sin but are equivocal to add that it is permissible as last resort to avoid any more childbirth which seems unaffordable to the family.

The sampled population is also grouped in terms of caste categories i.e. general caste, Scheduled Castes (SCs) and Other Backward Classes (OBCs). The percentages of sterilisation adopters across caste categories i.e. general, SCs and OBCs are 23, 44 and 33 per cent respectively. In the sampled population the SCs have highest sterilisation adoption, which is also significant ($t = 5.413$; $P < .05$). The variations in case of ever-temporary contraceptive usage among SCs and general categories are minimal that is 43 per cent and 42 per cent respectively, and in the case of OBCs, the percentage of ever-temporary users is 55. These results for SCs and OBCs negate the arguments that poor profligate and have lower adoption of family welfare programmes. Rather most poor category (that is SCs) in the sample performed better.

In terms of family typologies (that is nuclear and joint) the data do not provide a clear picture. However, within the category analysis shows that in nuclear families 51 per cent are adopters while in joint adopters percentage is 47. In case of ever-temporary contraceptive usage the variations are further insignificant (that is 48 per cent in nuclear and 47 per cent in joint families are ever-temporary contraceptive users). Thus relatively (at 4 per cent margin) nuclear families are more conducive to sterilisations than joint families. The case study (CSN-1) also illustrated that in joint families sterilisation adoption is complex and complicated and much delayed process due to intra-house deliberations in making final decision for sterilisation.

The sampled population have poor landholdings. Only a total of 13 per cent among adopters and 15 per cent among non-adopters have land holdings. Further, among adopters, 80 per cent of those having the land, have 2 or less *bigas* (1 acre = 5 *bigas*) of land. However, among non-adopters 45 per cent of landholders have 2 or less *bigas* of land and the rest landholders have land in the rest ranges from 5 *bigas* to 109 *bigas*. Thus, apparently landholders are poor sterilisation adopters. However, the case studies (CSN-2 and CSN-3) of clients with 50 *bigas* and 109 *bigas* of land make clear that land holding should be read with burden of responsibilities, paid employment of women and occupation categories like business and services of their spouses. Further in terms of political participation or power hegemony, the sampled population do not have long political history. Only a few have familial background of participation at village level that also due opportunities of reservation provided by 73rd Amendment of the Indian Constitution. However, the data show that this is positively influencing the family welfare programmes as 11 out of 13 with political background are adopters and as case study (CSN-4) makes clear that political participation and resultant interactions and exposures are positively stimulating small family norm and contraceptive adoption.

Thus with regard to socio-economic correlates it may be inferred that in the sampled population, religion as a category (across Hindus and Muslims) is not significant while caste is significant at least in sterilisation adoption. SCs are better sterilisation adopters however in case of temporary contraception SCs and general category are at the same platform while OBCs performed better. The family typology also does not presents a clear picture but in case of

sterilisation nuclear families are more conducive. Further, in terms of land holding and political participation, the sample population have poor profile however, those belonging to these categories are either adopters or have positive inclination towards family welfare programmes. The qualitative data more thoroughly reflect that these socio-economic correlates govern and operationalise subjective realms of adopters and non-adopters. For example, religion as an institution governs people's perception of children and differential acceptance of specific contraceptives that is no inhibitions for temporary contraceptives but much constraints and conservatism for sterilisation and notions are common both among Hindus and Muslims. The same religious rather cultural and community notions regarding sterilisation somehow argues why sterilisation is complex and complicated process in joint families. The data contradict the hypothesis that higher castes have higher adoption rather in case of sterilisation reverse is true, at least among the sampled population. It is also encouraging that those availing the opportunities of Constitutional Amendment have favourable attitude towards family welfare programmes and are even advocating the same among their families.

In the present research the personal and familial characteristics of the sampled population are cross tabulated across three major attributes- education, occupation and income. Coming to education, the family aggregate of adopters in illiterate category is 53 per cent (against 49 per cent of non-adopters), while in I to X standard and above X category it is 30 per cent and 8 per cent respectively. The percentages of non-adopters family aggregate in I to X and above X categories are 38 and 13 respectively. Thus in terms of family

aggregate educational status, non-adopters have better profile. Moreover, in terms of individual categories that is respondents themselves, their spouses and significant others, also the non-adopters are relatively better. Further in terms of individuals, spouses and significant others, the education of husband is significant both for adopters and non-adopters. Thus the sampled population data negate education as having significant bearing on sterilisation adoption.

However, occupation as a variable is significant for family aggregate (unlike education which was significant for husband) of adopters ($t = 3.470$; $P = .040$). The family aggregate percentage of adopters in house wife/ no work category is less than non-adopters but the relative aggregate of adopters is more in business, and service/skilled work categories than non-adopters family aggregate. The aggregate adopters and non-adopters percentage in agriculture, allied and unskilled work categories are same. In the individual category, adopters themselves percentages in comparison to non-adopters counterparts are less in house wife/ no work category (5 per cent margin). In case of their spouses, the business category seems more favourable to sterilisation. Further the significant others among adopters are less in house wife /no work category and in relation to non-adopters they are more in paid work category. Moreover, the equal percentage of adopters and non-adopters individual and family aggregates are in agriculture and works and hence negates the significance of this occupational category in the sterilisation adoption. Thus it may be inferred that higher the participation in paid work categories (that is

service, business etc. instead of house wife/ no work) higher the adoption of sterilisation.

The data on income levels reflect that adopters are relatively poor than the non-adopters. The 52 per cent of aggregate adopters unlike 46 per cent aggregate non-adopters are in less than Rs. 1000 per month income slabs while in Rs. 1000-3000 income slabs aggregate adopters and aggregate non-adopters have equal percentage i.e. 37 per cent and in Rs. 3000 and above income slabs aggregate adopters percentage is 11 against 16 per cent of non-adopters. Thus, unlike the occupation which is significant for aggregate adopters, the income levels are significant for non-adopters personal and familial aggregates. Thus, in terms of relative percentage of non-adopters in higher income slabs and significance of t-value for non-adopters, it may be safely inferred that poor are better sterilisation adopters.

Thus in regards to personal and familial characteristics of adopters and non-adopters following inferences can be drawn: that education and sterilisation are not significantly correlated; that occupation is significant for the adopters personal and familial aggregate and in case of adopters themselves the paid work category is significant while in case of their spouses, the service and business as occupational categories are important; that adopters have poor income levels than non-adopters counterparts.

To sum up, the data contradicts the religious categories as significant in contraceptive adoption and so is the case with education and land holdings. Further unlike the proposed hypotheses the lower castes and low-income

groups have better adoption while the nuclear families and political participation facilitate the adoption of family welfare programmes.

Reproductive trajectory

The sampled population reproductive career stars with an early age at marriage (aggregate mean 15.9 and for adopters and non-adopters the mean ages at marriage are 16.1 and 15.8 respectively), and early childbirth as more than three-fourth have first childbirth at the ages 15-20 years. They have long marital durations, for example among adopters it is 16.1 years while for non-adopters it is 11 years. Further the mean age at youngest/last childbirth is 30.4 years for adopters and 26.4 years fro non-adopters. Moreover, the average spacing between successive childbirths is also low. The adopters have experienced an average spacing of 2.29 years and for adopters it is 2.31 years. Coming to presently living children, the average for total sample is 4.1 living children. Among adopters and non-adopters it is 4.8 and 3.4 children respectively. Thus the data amply show that reproductive trajectory of the sampled population is typically same and their pregnancies pattern can be presented as- too soon, too close and more many. The focus group discussions and accounts of key informants also support the quest for first childbirth and even the very first pregnancy declaration has well-defined rituals and celebrations. These discussions also reflect the consciousness and helplessness of women in maintaining the spacing and limiting the family size and the same is the reason for induced abortions. The data also inform that apart from pregnancy load, women are also exposed to the pains and risks of pregnancy wastages and poor safe motherhood and safe delivery practices. Among

adopters, as much as 43 per cent experienced ever pregnancy wastage which is 20 per cent in case of non-adopters and in aggregate 31 per cent experienced ever pregnancy wastages. Among those aggregate adopters and non-adopters who ever experienced pregnancy wastages, 78 per cent experiences abortions (43 per cent natural and 30 per cent induces abortions) and 28 per cent experiences still births. (12 per cent with still births, 15 natural abortions and 16 induced abortions). Further average 75 per cent (both adopters and non-adopters) ever avail any ANC checkups. Similarly more than 50 per cent ever took any IFA tablets during pregnancies and interestingly those who took IFA tablets have poor intake of complete package. As much as, half among the adopters and non-adopters who availed services took less than 100 IFA tablets. In case of TT injections situation is relatively better as 59 per cent among adopters and 75 per cent among non-adopters ever took TT injections. Further in the total sample as much as 67 per cent ever had deliveries at home in presence of traditional birth attendants (*dai*). Moreover, the FGDs crystallise the inherent risks in delivery practices and cutting of umbilical cords and how both mother and child are exposed to risks of hypothermia and tetanus due to place of deliveries and used of instruments to cut umbilical cord respectively.

Thus, the poor reproductive trajectory of rural women forced them to take recourse in adoption of sterilisation which to them is more safer than unsafe abortions or being further puzzled of pregnancies and pregnancy wastages. The data therefore contradicts the proposed hypothesis that poorer the reproductive trajectory, poorer the adoption of family welfare programmes. This area require much needed attention of public health agenda and can be

fruitful for both saving the mothers and promoting the family welfare programmes.

Intra- house communication and power relations

In order to understand the significance of intra-house dynamics of communication and power relations, the present research dwelled across two hypotheses, one on communication domains and another on process of decision-making in the family.

Communication domains: The data collected show that there are differential variations of across family issues and discussions on the same with spouses and significant others. For example on general issues like domestic problems, economic and child upbringing issues, a high percentage (70 per cent and above) both among adopters and non-adopters discuss these with their spouses. However, on issues like personal health and hygiene, having small family and limiting family size, the adopters have higher percentages of discussions with their spouses. For example, on personal health and hygiene as much as 53 per cent non-adopters confine it to themselves (that is less discussions with other family members) which in adopter's case is only 25 per cent. Further, 83 per cent adopters against 53 per cent non-adopters discuss the idea of having small family with their spouse while on the issue of limiting family size, a sizable (85 per cent) adopter discuss it with their spouses against 65 per cent non-adopters. Thus, the adopters have wider communication domains than non-adopters and hence the hypothesis that higher the scope of

discussion on family issues (wider the communication domains), higher is the adoption of family welfare programmes is tested true.

Decision-making: Similarly, the decision making of these issues have variations across the issues and also among adopters and non-adopters. On general issues (domestics problems, economic issue and child upbringing) the decision making among both adopter and non-adopters is either by husband or mutually. Further, the decision on the issue of personal health and hygiene is either tackled individually by adopters (31 per cent) or mutually (36 per cent), only in 23 per cent and 11 per cent cases such decisions are taken exclusively by husbands and significant others respectively. Further, higher figures of mutual decision-making are on issues of small family (53 per cent) and limiting family size (52 per cent). It may also be noted that out of only 18 significant others of adopters 16 (89 per cent) became active decision makers on the issue of limiting family size while on other issues significant others do not figure more than 9 (50 per cent). Among non-adopters with regard to issue of personal health and hygiene, 61 per cent non-adopters themselves take decision (against 31 per cent adopters) and only 4 per cent mutually decide (against 36 per cent adopters). Further on the issue of small family 40 per cent argued to mutually decide (against 53 per cent adopters), for 32 per cent by husbands, for another 15 per cent by significant others and 13 per cent are bold enough to decide by themselves only. Similar is the response on limiting family, 39 per cent believe in mutual decision (against 52 per cent adopters), 31 per cent said their husband will decide while 17 per cent argued for significant others and 13 per cent said they themselves will decide. Thus, it

clear from both tables that unlike general issue like domestic problems, economic problems and even child upbringing, the intimate issues like personal health and hygienic, and the issues of small family and family limitation differs in decision making matters and these dynamics have to be considered in any mobilization for small family norm or adoption of family planning. It is also clear from the data that among adopters there is more mutual decision-making and this again supports the proposed hypothesis that higher the mutual decision making in family, higher the adoption of family welfare programmes.

Process of contraceptive adoption

The present research dwelled on the process of contraception- starting with first hearing about contraceptives to idea of usage, and the personal and familial responses thereupon and finally the contraception adoption.

Contraceptive Information

The data show that all the adopters heard of sterilisation (against 93 per cent non-adopters), 85 per cent heard of pills (against 83 per cent non-adopters), followed by 84 per cent adopters who heard of condoms (against 83 per cent non-adopters), 59 per cent heard of IUD (against 51 per cent non-adopters), 51 per cent about injectables (against 45 per cent non-adopters) and just 35 per cent heard of traditional methods (against 25 per cent non-adopters). In terms of timings when first heard of contraceptives, the negligible percentage of adopters and non-adopters heard about contraceptives before marriage expect of sterilisation (29 per cent adopters and 36 per cent non-adopters). Further

average 57 per cent adopters and 54 per cent non-adopters heard about condoms, pills and IUD during the period after marriage and II childbirth. While most come to know of traditional methods after III to V childbirth (73 per cent adopters and 79 per cent non-adopters). The peer group emerged out as a significant source for contraceptive information both for adopters and non-adopters. For example, among adopters, 32 per cent come to know of condoms from peers against 37 per cent non-adopters and similarly for other methods, peers contributions are 39 per cent for pills (against 37 per cent non-adopters), 48 per cent for IUD (against 47 per cent non-adopters), 58 per cent injectables (against 50 per cent non-adopters), 31 per cent for sterilization (against 29 per cent non-adopters) and as much as 81 per cent (against 84 per cent non-adopters) heard about traditional methods from their peers. The mass media's major contribution is in case of sterilization as 21 per cent adopters and 31 per cent non-adopters heard of sterilization from mass media. Coming to government health worker (ANM) as a source, her contribution in case of adopters information is – 21 for condoms (against 18 per cent non-adopters), 14 per cent for pills (against 16 per cent non-adopters), 25 per cent IUD (against 11 per cent non-adopters), 13 per cent injectables (against 15 per cent non-adopters) and 12 per cent fro sterilisation (against 10 per cent non-adopters). Thus, adopters have more information on contraceptives than non-adopters.

Contraceptive Adoption

In the total sample (150), the fifty per cent are sterilisation adopters (adopters) and equally are the non-sterilisation adopters (non-adopters). Further in the

sampled population only 48 per cent are ever-modern temporary contraceptive users (51 per cent among adopters and 45 per cent among non-adopters). In aggregate, the response percentage on temporary contraception is more for simple consent (69 per cent adopters and 55 non-adopters), followed by encouragement response (22 per cent in case of adopters and 38 per cent for non-adopters). On personal and familial responses, it may be noted that personal (adopters/non adopters themselves) responses are more positive than familial responses. For example, encouragement response at personal level is higher (42 per cent adopters and 53 per cent non-adopters) than familial (5 per cent spouses and 10 per cent significant others of adopters, and like 29 per cent spouses and 13 per cent significant others of non-adopters). While the familial responses are more in simple consent (87 per cent spouses and 50 per cent significant others of adopters, and 65 per cent spouses and 75 per cent significant others among non-adopters have simple consent response) than the adopters/ non-adopters self responses (55 per cent adopters and 75 per cent non-adopters themselves have simple consent). Moreover in total the responses for temporary contraception are more favourable among non-adopters than adopters and most importantly, there is no response of outright rejection for temporary contraception. However, in case of sterilisation, of the aggregate personal and familial responses, the major responses are of simple consent (51 per cent) followed by that of encouragement (27 per cent) and even 10 per cent responses are that of rejection which was nil in case of temporary contraception. Further, the encouragement response for sterilisation is relatively more among adopters themselves (43 per cent) than their spouses (12 per cent) and significant others (28 per cent).

However, unlike the responses, the decision-making process among adopters is more participatory than non-adopters. For example in case of condom usage, 81 per cent adopters jointly decided with spouses, which is 76 per cent in case of non-adopters. Similarly, in case of oral contraceptive pills 76 per cent adopters (against 73 per cent in case of non adopters) decided jointly with their husbands. Further unlike condoms, in case of pills, the significant others also have participation in decision making, both among adopters and non-adopters. Only among non-adopters, 2 per cent of the pills users have decided to use it by themselves (self only). There are only three cases of intra uterine contraceptive device (IUCD) users, one among adopters and two among non adopters and all decided to adopt the same by their self only decision. In case of sterilisation 58 per cent decided jointly with husband, 11 per cent jointly with significant others. In sterilisation there are also extremes. For example 25 per cent took unilateral decision while in 5 per cent cases the decision making was highly participatory i.e. adopters, their husbands and significant others mutually decided to adopt sterilisation. In only one case, there was no say of adopter while she undergoes sterilisation.

It thus came out from above discussion, that in case of temporary contraception responses are more of simple consent and encouragement than of indifference and even there is no response of rejection. Among non-adopters, the responses are relatively more positive than adopters. However, the process of decision-making is more participatory among adopters than non adopters and probably the same speak of high percentages of adopters in ever-temporary contraception than non-adopters. Similarly, in case of sterilisation

also there is either more mutual decision-making (all adopters, their spouses and significant others) or extreme unilateral decision by women. It may be noted that in case of temporary contraception there was not even a single case of mutual decision-making, this again justifies that in case of sterilisation whole family becomes active thus decision making becomes complex. Thus the hypotheses: i. more positive the personal and familial response to contraceptive methods, more the adoption of contraceptives; and ii. more participatory the decision making process, more the adoption of contraception are tested true.

In view of the supra, and detailed discussions in specific chapters, it is amply clear that contraception is a dynamic process involving family as a whole rather than the individuals. Further, the mutual discussions and participatory decision-making processes governs to a large extent the adoption of contraceptives and becomes more important as one moves from temporary contraception to permanent methods like sterilisation. However, the extent and level of mutual discussions and pace of decision-making in contraceptive adoption depends upon the synchronisation between personal and familial characteristics. This it may safely be said that –higher is the synchronisation between personal and familial characteristics, higher is the adoption of family welfare programmes.

7.2 Ways forward

The state and society both have to compromise their respective expectations from each other and the family planning programme has to be recognised as

an integral part of the overall development plans.[4] It is rightly noted that 'there is no shortcut to population stabilisation. There is no substitute to sustained good work. We must create a situation where people would ask for health and family planning services.'[5] The results of present research proved beyond doubt the importance of the intra-house dynamics of communication and power relations in the contraception adoption and how discussions and delayed decisions in family results in a long gap between the parity at which one decides to limit family and the parity at the time of sterilisation. Thus if proper threshold energy is provided to speed up this process than family planning catch segment will not be the exhausted generation but the potentials groups to substantially strike at TRF. It has also become very evident that unlike sterilisation there are not much inhibitions regarding temporary contraception, rather there is high unmet need. However, the hassles and infectiveness of temporary contraceptives is a cause of concern among the sampled population. From the qualitative data it became crystal clear that the only missing link is the lack of proper counselling and clarification regarding temporary contraceptives which results in incorrect and inconsistent use of temporary contraceptive and hence the resultant effectiveness. It also came out that due to delay in process of decision-making for sterilisation and ineffectiveness of temporary contraception, the women attempt fatal traditional concoctions and unsafe abortions. Thus, there is need of concrete steps for developing such groups within community who can act as catalysts to provide the much needed threshold energy. Here lies the proactive role of Panchayati Raj Institutions (PRIs) and the social worker professionals to

[4] Pathak and Singh, "Fertility Transition in India.", p. 195.

[5] Bose, *From Population to People.*, p. 125.

provide true momentum to Cairo goal of informed choices in contraceptive adoption under the umbrella concept of Reproductive Health (RH).

Panchayati Raj Institutions (PRIs): India presents a unique case in terms of the sheer number of people involved and the extreme heterogeneity of its cultures, languages and socio-economic conditions. 'To improve the effectiveness of the family planning programme, it must be decentralized to reach the grass-roots level.'[6] A Working on population appointed by Planning Commission in 1978 (report submitted in 1980) expressed the opinion that the task will not be easy to achieve unless the programme of family planning had the fullest participation of the people, individual and through their representative institutions, voluntary associations, local organisations etc. and in backdrop to same, a study on people's participation in family planning was launched by Panandiker and Mehra[7]. They compared the two models of people's participation i.e. voluntary organisation and panchyats and selected a sample 30 villages and 3 urban centres from the working areas of four voluntary organisation (from states of Gujarat, Delhi and Maharastra) and two panchayat models covering 15 villages (from Madhya Pradesh and Gujarat). It was observed that the shift was more tactical and the ambivalence was evident from the fact that neither a proper definition of people's participation in this context was made, nor an overall strategy evolved through which such participation could be achieved or ensured.[8] They concluded that despite policy professions, over the years, very little conscious effort appears to have

[6] R. Gandhi, "Gandhi Addresses the World on Family Planning," *International Family Planning Perspectives* 8, no. 3 (1989).

[7] Panandiker and Mehra, *People's Participation in Family Planning.*

[8] Ibid., p. 10.

been made to move in that direction.[9] The study also noted that voluntary agencies have done relatively better than the two panchayats models both in mobilising participation as well making family planning a popularly acceptable programme.[10] The Tenth Plan[11] also emphasized the need to devolve responsibilities and funds to panchayati raj institutions. More recently, Bose[12] observed India's planners and policy makers as well as administrators of the family planning programme (lately called RCH programme and very recently called population stabilisation programme) have always emphasized the need for family planning as a "people's movement" without spelling what exactly is meant by this piece of rhetoric. Even today the so-called people's movement remains an empty dream. However, with the recent amendments in the Constitution of India and consequent empowerment of Panchyati Raj Institutions (PRIs), there appears a ray of hope. Santha[13] noted that with the 73rd and 74th Constitutional amendments and the passing of Panchayati Raj and Nagar Palika Acts in 1992, the family planning programme is legally brought in the domain of Panchayati Raj Institutions. As result of this constitutional the Article 243G of Indian Constitution provides for 'power, authority and responsibilities of Panchayats' and reads:

> Subject to the provisions of this constitution the legislature of a State may, by law, endow the Panchayats with such powers and authority as may be necessary to enable to function as

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[9] Ibid., p. 249.

[10] Ibid., p. 236.

[11] Jejeebhoy et al., "Setting the Stage.", p. 20.

[12] Bose, *Beyond Demography- Dialogue with People.*, Preface, p. x.

[13] Santha, "Contraceptive Use Dynamics.", pp. 39-40.

> institutions of self-government and such law may contain provisions for the devolution of powers and responsibilities upon Panchayats, at the appropriate level, subject to such conditions as may be specified therein, with respect to- (a) the preparation of plans for economic development and social justice; (b) the implementation of schemes for economic development and social justice as may be entrusted to them including those in relation to matters listed in the Eleventh Schedule.[14]

Moreover, the matters listed in the Eleventh Schedule have 29 subjects and its item 25 reads as 'Family Welfare' and further this is preceded by item 23 and item 25 which includes areas 'Health and Sanitation including hospitals, primary health centres and dispensaries'; and 'Women and Child Development'.[15] These provisions make PRIs constitutionally empowered enough to ushers in a new era participatory development including family planning and RCH (Reproductive and Child Health). This seems to be the moment where we should abandon the number game and move from population to people.[16] The recently launched National Rural Health Mission of Government of India have heavily relied on PRIs in the selection, payment and monitoring of the grassroots activist of the programme called as ASHA. However, it came out from very limited experiences that these newly appointed ASHAs have simply became the assistant of health workers. Thus,

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[14] P.M. Bakshi, *The Constitution of India (with Selective Comments by P.M. Bakshi)*, (first published 1991) fifth ed. (Delhi: Universal Law Publishing Co. Pvt. Ltd., 2002)., p. 208.

[15] Ibid., p. 391.

[16] Borrowed from the suggestion on the same put forward way back in 1988 by Ashish Bose. See Bose, *From Population to People*., p. 24.

the PRIs have an important role in streamlining the programme which has just made its beginning.

Social work professionals: It is rightly noted that the mass media can play an important role in promoting awareness, whereas interpersonal communication can play a very important role in changing behaviour and promoting the acceptance of family planning among a variety of people.'[17] Here lies the role of social work professionals with their specialised knowledge of human behaviour and scientific skills of handing the problems. During 1970s like others disciplines there were also much initiatives in outlining and streamling the roles of professional social workers in family planning. The premier social work institute i.e. TISS (Tata Institute of Social Sciences) recognising the need for active participation in family planning programme made compulsory a two-month training course at the Government of India, Family Planning and Research Centre, Bombay to a group specialising in Family and Child Welfare.[18] On this Gore noted that it would be very useful if all other groups could also have this advantage, so that they could become active participants in promoting family planning through their specific responsibilities, whether as a labour welfare officer, child guidance worker, or a social worker.[19] However, that was the time of much talked target centric approach where social workers with their process-oriented aspproach were poor target chasers. However, with Cairo focus of reproductive rights, individual choices,

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[17] Zodgekar, "Family Welfare Programme and Population Stabilization Strategies in India."

[18] Sushila S. Gore, "Family Planning- a Social Responsibility," in *History and Philosophy of Social Work in India*, ed. A.R. Wadia, *Tata Institute of Social Sciences Series No. 14* (Bombay: Allied Publishers Private Limited, 1968)., p. 142.

[19] Ibid., p. 142.

informed consent and Government of India failed experiments with a plethora of approaches based on targets and now propagation of target free approach and client centred initiatives, provides a space for social work professionals to contribute on this issue. Moreover, the results of this research strongly argue for concentrated efforts to develop such groups who can play the role of animators on reproductive health issues including family planning. In the capacity building of such groups, professional social workers can play a significant role. However, for this it is also necessary that social professionals should be specially trained on such issues during their graduate/post-graduate days and thus there is a need to first make RH training as an integral part of social work curriculum and field practicum.

7.3 Limitations

The study has attempted to explore the dynamics of contraceptive adoption with the help of exploratory research design at micro-level. The study used both the quantitative as well as qualitative data come drawn inferences. However, the study is restricted to a sub-centre with a sample of 150 respondent, 75 sterilisation adopters and 75 non-sterilisation adopters and probably this seems to be the biggest limitation of this research. Further, there are many more dimensions of family welfare programmes however; the research was restricted only to contraception adoption. Nevertheless, the research study was successful in achieving its objectives, and the findings of the study can be effectively used for intensifying the process of contraceptive adoption.

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APPENDICES

APPENDICES

INTERVIEW – SCHEDULE

"Personal and Familial Characteristics in the Adoption of Family Welfare Programmes – An Analysis of Lodha Block, Aligarh"

Department of Sociology and Social Work
Aligarh Muslim University, Aligarh

(Note: Questions i-v to be filled from Master Sheet and questions vi-vii at the end from tab. 3.1)

i. Block: ☐
(1. Lodha, Aligarh)

ii. PHC: ☐
(1. Nehra)

iii. Sub- Centre: ☐
(1. Jalalpur)

iv. Name of Village: ☐
(1. Ashrafpur Jalal 2. Alahadadpur Nivry)

v. Sterilisation status ☐
(1. Adopter 2. Non-adopter)

vi. Temporary Modern contraceptive methods ☐
(1. Ever use 2. Never use)

vii. Traditional contraceptive methods ☐
(1. Ever use 2. Never use)

(Date and Signature of Researcher)

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* Head of Household (HH): ☐
(1. Respondent 2. Spouse 3. Mother-in-law
4. Father-in-law 5. Brother-in-law 6. Sister-in-law)

* Name of Head of Household (HHH): .....

* Name of Respondent:.....

PART- I: SOCIO-ECONOMIC AND DEMOGRAPHIC PROFILE

1.1. Religion: ☐
(1. Hinduism 2. Islam 3. Sikhism
4. Christianity 5. Buddhism 6. Other)

1.2. Caste: ☐
(1.General 2. SC 3. ST 4. OBC)

1.3. Family Profile:

1.3.1 Type of Habitation ☐
(1. Kuchcha 2. Pucca 3. Mixed)

1.3.2 Nature of Family ☐
(1. Nuclear 2. Joint)

1.3.3 Family size (both adults and children) ☐

1.3.4 Education, Occupation and Income Details

Family Members	Education 1. Illiterate 2. Madarsa 3. I-V 4. VI-VIII 5. IX-X 6. XI-XII 7. Graduate 8. P.G. & Above	Occupation 1. Housewife 2. Agriculture & Allied 3. Business 4. Services 5. Skilled worker 6. Unskilled 7. No Work 8. Other	Income (Rs. per month)	Expenditure (Rs. per month)
1. Respondent				
2. Husband				
3. Significant Other (Head of HH /decision maker)				

1.3.4.1 Total monthly family income Rs..... and total monthly family expenditure Rs.....

1.3.4.2 Total family agricultural land (in *bigas*): .....

1.3.5 Is/was anyone in family holding/held any elected political post (1. Yes 2. No) ☐

If yes, then at which level (1. Village 2. Block 3. District) ☐

1.4 Demographic Details

1.4.1 Present Age of couples, age at marriage and years of cohabitation

Couple	Age (in years)				
	1. Present Age	2. Age at Marriage	3. Marital Duration	4. Age at First child birth	5. Age at Last /smallest child birth
Respondent					
Husband					

1.4.2 No. of Pregnancies and Child Birth

Pregnancy Outcome	2.Total no. of Children		3.Outcome and Place of Deliveries								Total
			Institutional				Home Based				
			Govt. Hospital		Private Hospital		Trained		Untrained		
	Male (M)	Female (F)	M	F	M	F	M	F	M	F	
1. Presently living children											
2. Any child died in past											
3. Still births											
4. Abortions (natural)											
5. Abortions (induced)											

1.4.3 Antenatal care during pregnancies

1.4.3.1 Did you ever gone for Antenatal checkups (1. Yes 2. No) ☐

If yes, how many times (write number) ☐

1.4.3.2 Did you ever took IFA (Iron and Folic Acid) tablets (1. Yes 2. No) ☐

If Yes, how many (write number) ☐

1.4.3.3 Did you ever took Tetanus injections (TT) (1. Yes 2. No) ☐

If yes, how many (write number) ☐

PART-II: INTRA HOUSE DYNAMICS OF COMMUNICATION AND POWER RELATIONS

2.1. Rationale of Ideal family: Opinion on Ideal Family, its size and reasons

Family Details	Opinion on type of Ideal Family one wants/likes 1. Small 2. Large	No. of children in ideal family		Reasons of likeness ***(only one main reason)***	
		1. Male	2. Female	If Small, 1.Difficult to afford many children 2. Division of land 3. Wants quality upbringing 4. Nations development 5. Other (specify)	If Large, 1. Children economic asset 2. More hand more power i.e. hegemony 3. Security in old age 4. Not sure about their survival 5. Children gift of God 6. Other (specify)
1. Respondent					
2. Husband					
3. Significant Other					

2.2. Family Issues, Communication Domain and Decision Making

Issues	Discussion with family members ***(only one option)*** 1. Self only 2. Husband 3. Significant Other	Who takes final decision 1. Self only 2. Husband 3. Significant Other 4. Mutually
1. Routine domestic problems		
2.Economic issues		
3. Child upbringing		
4. Personal Health & Hygiene		
5. Idea of having small family		
6. Limiting Family size		

PART-III: ADOPTION OF FAMILY WELFARE PROGRAMME

3.1. Information and adoption of family planning methods

Family Planning Methods	When did you first heard of specific device 0. Before Marriage 00. After marriage but before Ist birth 1. After Ist birth 2. After 2nd and so on i.e. 3,4....	Source of first information 1. Govt. Health worker 2. Voluntary health worker 3. Mass media 4. Local IEC 5. Spouse 6. Other family members 7. Peers	First ever use of specific method 0. Before Marriage 00. After marriage 1. After Ist birth 2. After 2nd birth and so on i.e. 3, 4...	Availability/ procurement 1. Govt. Health worker 2. Voluntary health worker 3. Market 4. Other (specify)	If switch over, Main Reasons ***(only one main reason)*** 1. Usage problem 2. Procurement problem 3. Spouse don't like 4. Side effects 5. Problem at coitus 6. Expensive 7. Other (specify)
1. Condoms					
2. Pills					
3. IUD (Cu-T)					
4. Injectables					
5. Sterilisation					
6. Traditional methods					

3.2. Monthly expenditure on family planning services: Rs...

3.3.1 Personal and familial response on sharing the idea of contraceptive adoption

Family planning method/s Adopted	Sharing the idea of adopting family planning methods and responses of family members Responses code: 1. Encouragement 2. Simple consent 3. Indifference 4. Rejection			Aggregate family's decision /view 1. In favour of adoption 2. Against adoption	Net Results 1. Adopted 2. Not Adopted
	1. Self	2. Husband	3. Significant Other		
1. Condoms					
2. Pills					
3. IUD (Cu-T)					
4. Injectables					
5. Sterilisation					
6. Traditional methods					

3.3.2 Participation in the process of contraceptive adoption

Family planning method/s Adopted	Participation in Decision Making 1. Jointly with husband 2. Jointly with significant other 3. Self only 4. No say 5. Mutual (Self, Husband and significant others)
1. Condoms	
2. Pills	
3. IUD (Cu-T)	
4. Injectables	
5. Sterilisation	
6. Traditional methods	

3.4 If sterilisation adopter (else move to 3.5)

3.4.1 Date of Sterilisation (month & year): .....& Age at Sterilisation (years):.....

3.4.2 Main reason for Sterilisation adoption ***(only one main reason)***: 1. Health concern 2. Quality upbringing of children 3. Economic compulsions 4. Husband pursued 5. Other Family members pressurized 6. Peer pressure 7. Health worker motivated 8. Children going to marry/married 9. Don't want any more child 10. Incentives (specify) 11. Other (specify)

3.4.3 Process of undergoing Sterilisation

Process of Sterilisation Adoption	Sterilisation adopter (only one main reason/response)
Initial Inhibitions (only one main inhibition) 1. No inhibition 2. Worried about spouse response 3. Worried about family response 4. Worried about community sanctions 5. Going for operation (i.e. Sterilisation) 6. Other (specify)	
Who gave clarification (in case of inhibition) 1. Spouse 2. In laws 3. Peer group 4. Govt. Health worker 5. Voluntary Health worker 6. Other (specify)	
Place of Sterilisation: 1. PHC 2. Distt. Hospital 3. At Pvt. Clinic	
Pre-adoption counselling given: 1. Yes 2. No	
Major complications 1. Abdomen pain 2. Headache 3. Backache 4. Constipation 5. Irregular bleeding 6. Surgical complication 7. Other (specify)	
Follow up services given : 1. Yes 2. No	
Sterilisation success: 1. Yes 2. No	
Finally satisfied: 1. Yes 2. No	

3.4.4 Do you know sterilisation is irreversible (1. Yes 2. No) ☐

3.4.5 Did you sign the consent form (1. Yes 2. No 3. Spouse signed 4. Don't know) ☐

If yes, did you read/heard the content of consent form (1. Yes 2. No) ☐

3.4.6 Any Sterilisation case in family before your Sterilisation (1. Yes 2. No) ☐

3.4.6.1 Is anyone in family has gone for Sterilisation after you (1. Yes 2. No) ☐

3.4.7 Most important personal benefit after sterilisation adoption ***(only one main reason)***: ☐
1. Reduced risk and concern about unwanted pregnancies/ enhanced sex life
2. More freedom to carry activities 3. Reduced domestic work
4. Status upgradation in family 5. Husband satisfaction 6. None 7. Other (specify)

3.4.8 Negative Consequences of Sterilisation adoption ***(only one main consequence):*** ☐
1. Rift in family 2. Community sanctions 3. Sanctions on observance of religious rituals 4. Frustration of not having more children
5. None 6. Other (specify)

3.4.9 Did other women of village came to seek your advice on Sterilisation (1. Yes 2. No) ☐

3.4.10 Did you yourself motivate others (1. Yes 2. No) ☐

3.4.11 Did health worker use you as a Model for motivating others (1. Yes 2. No) ☐

3.5 Non Contraceptive / Non Sterilisation adopter

3.5.1 If no family planning method is used in past (else move to 3.5.2)

3.5.1.1 Main reason for not using any family planning method ***(only one main reason)***: ☐
1. Don't know about FPDs 2. No easily available 3. No need 4. Against religion
5. Husband disfavour 6. Significant others are against use 7. Expensive 8. Side effects
9. Other (specify)

3.5. 2 If only non Sterilisation adopter

3.5.2.1 Any Sterilisation case in your family (1. Yes 2. No) ☐

3.5.2.2 Main reason for not adopting sterilisation ***(only one main reason)***: ☐
1. Want more children 2. Against religion 3. Fear of operation 4. Can't do work after sterilisation 5. Post operation consequences 6. Expensive 7. No need 8. Husband disfavour 9. Family disfavour 10. Not easily accessible 11. Other (specify)

3.5.2.2.1 If answer to question 3.5.2.2 is 1(want more children) than after how many more children(write number of children) ☐

3.5.3 Are you planning to adopt sterilisation in future (1. Yes 2. No 3. Not sure) ☐

Any other information/ comments of the Researcher:

FOCUS GROUP DISCUSSIONS (FGDs) INVENTORY

FGD No.	Participants	Facilitators	Theme/ sub-themes	Summary
FGD-1 (Chapter- 3)	10 Hindu women in the age group 25-40 years. A mix group of Adopters and Non Adopters	Researcher ANM ASHA	Religion and contraception ▪ Perception about children ▪ Need of birth control ▪ Permissible methods of birth control	▪ Both groups consider children as evidence of God blessings ▪ Groups considered self control as best method but argued for its impracticality ▪ Both groups showed no inhibitions on use of temporary contraceptives ▪ Both groups consider sterilisation against the nature/ religion ▪ Adopters in both groups argued that they have taken it as last resort and hope to be 'forgiven' for the same.
FGD-2 (Chapter- 3)	10 Muslim women in the age group of 25-40 years. A mix group of Adopters and Non Adopters	Researcher ANM ASHA		
FGD-3 (Chapter- 4)	15 members mixed group of Adopters and Non Adopters with age range from 20-45 years	Researcher ANM ASHA CMC	Reproductive Trajectory ▪ Ideal age for marriage ▪ Timing of first childbirth ▪ Concerns on child mortality ▪ Pregnancy load and wastage ▪ Safe motherhood and safe delivery practices	▪ Preferable age for marriage as 13-15 years but not later than 16 years (Maxim is- earliest the better) ▪ Soon after marriage it is not only child birth rather the very first pregnancy is much awaited and a matter of rejoice and celebrations for both elder generations and young daughter-in-law who has to pass her test of fertility ▪ Group did not show much concern /fear of child mortalities ▪ Poor pregnancy care- ANC unaffordable, conscious of TT but over conscious of IFA initial side effects ▪ Prevalence of highly unsafe deliveries and abortions ▪ Elder ladies are perplexed of pregnancy load and respite first is unsafe abortion

FGD No.	Participants	Facilitators	Theme/ sub-themes	Summary
				and latter on sterilisation
FGD-4 (Chapter- 5)	10 women Adopters and Non Adopters in the age group of 25-35 years	Researcher ANM ASHA	Communication and power dynamics ▪ Family issues and intra-house dynamics of communication and power relations	▪ Participatory and joint decision making on general issues. Only in case of personal health and hygiene are reserved. However, relatively adopters have high percentage of discussions and mutual decision making on issues like personal health and hygiene, having small family and limiting family size ▪ In case of the issue of small family and its limiting the discussion starts quite late in the marital life and here it is the women perturbed by the pregnancies, child births and poor economic conditions take the initiatives.
FGD-5 (Chapter- 6)	10 ever temporary contraceptive users women in the age group of 25-30 years	Researcher ANM ASHA	Process of Temporary Contraceptive Adoption ▪ Response on initial sharing of the idea to use the same Participation in decision making ▪ In between the two dynamics	▪ In case of temporary methods the decision making is simple and easy ▪ Group did not show any inhibitions in the use of temporary methods
FGD-6 (Chapter- 6)	10 women with sterilisation in the age group 30-45 years	Researcher ANM ASHA	Process of sterilisation Adoption ▪ Response on initial sharing of the idea to use the same	▪ Decision-making is complex and gets much delayed which results in another pregnancy, childbirth or unsafe abortion, before the final decision to undergo sterilisation. Hereafter family gives it half

FGD No.	Participants	Facilitators	Theme/ sub-themes	Summary
			▪ Participation in decision making ▪ In between the two dynamics	hearted indifferent consent or women themselves take unilateral decision for sterilisation
FGD-7 (Chapter- 6)	10 ever temporary contraceptive user women both from Adopters and Non Adopters	Researcher ANM ASHA	Experiences of temporary contraceptive usage ▪ Procurement ▪ Usage ▪ Reliability ▪ Hassles	▪ Group showed much disappointment with regard to the ineffectiveness and reliability of temporary methods like condoms and pills. ▪ Group vehemently argued on hassles of using condoms and pills particularly the problems like unrolling of condoms and raptures and schedule mismanagement of pills
FGD-8 (Chapter- 6)	10 women both Adopters and Non Adopters in the age group of 35-45 years	Researcher ANM ASHA	Traditional contraception ▪ Typology of traditional methods ▪ Preparations of Concoctions ▪ Assumed effectiveness ▪ Inherent risks	▪ Prevalence of traditional concoctions *albeit* secretly ▪ Traditional methods are categorized as those with 'hot' and 'cold' properties (*tasheer*) and accordingly concoctions or like with cold properties are used 'to avoid conception' while those with hot properties are used 'to start the menstruation'. ▪ Group was conscious of risks inherent in these methods but argued for their effectiveness especially those with hot properties.
FGD-9 (Chapter- 6)	10 Adopter women with average number of 4.7 children at the time of	Researcher ANM ASHA	Experiences after sterilisation ▪ Initiatives and Inhibitions	▪ Economic compulsions, pregnancy loads and mothers concern for child upbringing results in initiatives for sterilisation

FGD No.	Participants	Facilitators	Theme/ sub-themes	Summary
	sterilisation		▪ Complications and consequences	▪ Major inhibitions are that of very word 'operation' ▪ Common post sterilisation complication is that of gastric and constipation Most positive aspect of sterilisation is no fear of pregnancy and childbirth
FGD-10 (Chapter- 6)	15 Non Adopter women both ever temporary contraceptive users and never users in the age group of 20-30 years	Researcher ANM ASHA	Understanding Non Adopters: Ever-temporary contraceptive users and never contraceptive users ▪ Knowledge of contraceptives ▪ Need of contraceptives ▪ Use of temporary contraceptives ▪ Problems in temporary contraceptive usage ▪ Need and concern for sterilisation	▪ Lack of awareness of temporary contraceptives ▪ Ever users lack knowledge of correct and consist use ▪ Fear of sterilisation

CASE STUDIES SUMMARY

Case Study No. (CSN)	Original Case No.	Client profile	Theme	Inferences
CSN-1 (chapter-3)	58/A	Guddo, a muslim woman aged 30 years and underwent sterilisation at the age of 28 years with 5 children (3 males and 2 females) against 8 pregnancies. She lives in a joint family	Family Type (Nuclear or Joint) and sterilisation adoption	In joint families sterilisation adoption is a complex and complicated process and is much delayed due to intra-house deliberations in making final decision for sterilisation.
CSN-2 (chapter-3)	35/A	Satyawati, a Hindu woman aged 30 years and underwent sterilisation at the age of 28 years with 5 children (4 males and 1 female) against 7 pregnancies. She belongs to OBC caste category and lives in a joint family with 50 *bigas* of land.	Land holding and sterilisation	Land holding becomes insignificant if burden of responsibility falls on significant others. The occupation of women herself matters as Satyawati is a health volunteer so was her exposure and persuasion skills.
CSN-3 (chapter-3)	17/NA	Rajwatii, a Hindu woman aged 38 years and is a non-adopter with 2 children (both males) against 2 pregnancies. She lives in a joint family with 109 *bigas* of land.	Land holding and sterilisation	Land holding becomes insignificant in case of majority in family being engaged in service as primary occupation.
CSN-4 (Chapter-3)	31/NA	Sucheta, a Hindu woman aged 35 years and is a non-adopter with 3 children (1 male and 2 females) against 4 pregnancies. Her father-in-law has been elected *gram pradhan* and family also own a land of 25 *bigas*.	Political participation	Elected political participation encourages and exposes with new outlook and quality of life and virtues of small family.
CSN-5 (Chapter-4)	49/A	Munni who has her wedding (*vivāh*) at the age of 9 years and thereafter departure to conjugal home (*gaunā*) at the age of 13 years	Wedding (*vivāh*) and consummation of marriage (*gaunā*)	Practice seems to also decline and accordingly to client no one now likes two times arrangements and in her family she was the last with *vivāh* and later on *gaunā*.
CSN-6 (Chapter-4)	19/NA	Urmila who has her wedding (*vivāh*) at the age of 12 years and thereafter	Wedding (*vivāh*) and consummation of	She also argued that practice has declined. Now from both sides there is concern to do

Case Study No. (CSN)	Original Case No.	Client profile	Theme	Inferences
		departure to conjugal home (*gaunā*) at the age of 15 years	marriage (*gaunā*)	both *vivāh* and *gaunā* together.
CSN-7 (Chapter-5)	25/NA	Meena, aged 35 years is a non adopter with a parity of 5 children (1 male and 4 females)	Parity matrix and *demographic fundamentalism*	Longing for 2 male children irrespective of number of daughters.
CSN-8 (Chapter-5)	29/NA	Rambati, aged 33 years has 2 daughters and is a non adopter	Parity matrix and *demographic fundamentalism*	To client daughters are not counted in family, family is with sons and socially expected minimum is of 2 sons.
CSN-9 (Chapter-6)	31/A	Santosh Kumari aged 28 years and married at the age of 18 years. She undergoes sterilisation at the age of 27 years with 5 children (3 males and 2 females)	Self rejection for sterilisation	She was not ready for sterilisation due to the fear/phobia of undergoing operation but in this case her husband played the lead role.
CSN-10 (Chapter-6)	32/A	Savitri, aged 44 and married at 18 years of age. She undergoes sterilisation at the age of 39 years after 6 children against 8 pregnancies	IUCD debacle	She suffered failure of IUCD and due to same reasons had both unwanted child and unsafe abortions and finally she took relief in sterilisation
CSN-11 (Chapter-6)	48/A	Anita aged 27 years and married at the age of 20 years. She underwent sterilisation at the age of 23 years with 2 children (both males)	Sterilisation at the parity of 2 children	Anita after the birth of first child started spacing but ended with another childbirth, again a male. Having two males, she argued that to her only best way for not having any more childbirth was sterilisation.
CSN-12 (Chapter-6)	57/A	Aara aged 35 and married at the age of 15 years underwent sterilisation at the age of 33 years with 8 children against 11 pregnancies	Sterilisation after 8 children	Client started using temporary contraceptives like condoms and pills after fifth childbirth but usage did not prevent birth of three more children. She also underwent two unsafe abortions and the complications in last abortion resulted in having sterilisation at the district hospital

Case Study No. (CSN)	Original Case No.	Client profile	Theme	Inferences
CSN-13 (Chapter-6)	25/A	Gaytri aged 36 years underwent sterilisation at the age of 32 years with 5 children but it failed resulting into birth of a female child and 2 more abortions.	Sterilisation failure and woman ordeals	Gaytri condition became pathetic after the failure of sterilisation. Her husband like anything has tortured her. She is also unable to successfully used temporary contraceptives and result was one female child and two unsafe abortions. After the last abortion her physical and mental conditions deteriorated and she is willing again for sterilisation but her husband is resisting the same.